

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11821 CERTIFICATE OF DEATH

11765

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Williamsport Md.		c. LENGTH OF STAY IN lb 65 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Williamsport Md. RFD #2							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williamsport Md. RFD #2				d. STREET ADDRESS Williamsport Maryland RFD 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Stewart (Hill) Ardinger		First	Middle	Last	4. DATE OF DEATH Oct. 2 1958	Month	Day	Year			
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 28 1892	9. AGE (In years last birthday) 65 yrs.	10. IF UNDER 1 YEAR Months 9	11. IF UNDER 24 HRS. Days 3	Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) Williamsport Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.					
13. FATHER'S NAME Charles Ardinger				14. MOTHER'S MAIDEN NAME Louisa Woltz							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. No 705 10 5000		17. INFORMANT Mrs. Ida Ardinger Williamsport Md. #2		Address RFD					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 140.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that I attended the deceased from _____ to _____, that I last saw the deceased alive on _____, and that death occurred at _____, from the causes and on the date stated above. ACTUAL SIGNATURE Physician's NAME (Type) Ralph E. Young											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 5 1958		22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery		22d. LOCATION (City, town, or county) Williamsport Maryland		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Albert Leaf Williamsport, Md		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 3 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kline					

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11822

CERTIFICATE OF DEATH

Reg. Dist. No.

11766

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Williamsport Md.		c. LENGTH OF STAY IN 1b 36 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williamsport Md RFD #2		e. STREET ADDRESS Williamsport Md. RFD #2	
3. NAME OF DECEASED (Type or print) Samuel Marcelus Ausherman		4. DATE OF DEATH Oct. 24 1958	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Oct. 22 1879	9. AGE (In years lost birthday) 79 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farm Owner		10b. KIND OF BUSINESS OR INDUSTRY Farm	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Hamilton David Ausherman		14. MOTHER'S MAIDEN NAME Julia Ann Bowers	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Linnie Ausherman		Address Williamsport Md. R. F. D. #2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary insufficiency 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 min (estimated) 2 yrs. 3 mos.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) None		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/31/56 , 19, to Oct. 24 , 1958, that I last saw the deceased alive on Oct. 13 , 1958, and that death occurred at 1:50 M, from the causes and on the date stated above. DST ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>William T. Layman, M.D.</i>		M.D. 100 Professional Arts Bldg. 10/25/58	
PHYSICIAN'S NAME (Type) William T. Layman, M.D.		Hagerstown Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 27-58	
22c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Albert Leaf Williamsport, Md.</i>		ADDRESS	
		24a. REC'D BY REGISTRAR DATE OCT 28 '58	
		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BY THE NATIONAL INSTITUTE OF MUSEUMS AND LIBRARIES
HEARD IN CHAMBERS

DR. JOHN STRAUFER
 145 S. PROSPECT ST.
 HAGERSTOWN

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11770

CERTIFICATE OF DEATH

11767

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE [Where deceased lived. If institution, Residence before admission] a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		b. COUNTY WASHINGTON	
c. LENGTH OF STAY IN 1b 2 DAYS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BOONSBORO	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH. CO. HOSPITAL		d. STREET ADDRESS NORTH MAIN STREET EXTENDED	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First EDWARD	Middle LAWSON	Last BABBINGTON
4. DATE OF DEATH	Month OCTOBER	Day 21	Year 1958
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH NOVEMBER 3 1868
			9. AGE (In years last birthday) 89 yrs.
			IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED CARPENTER		10b. KIND OF BUSINESS OR INDUSTRY BUILDING IND.	
11. BIRTHPLACE (State or foreign country) HARMONY FRED.CO.MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOSEPH BABBINGTON		14. MOTHER'S MAIDEN NAME CAROLINE WISE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. 219 20 0771	
17. INFORMANT ROGER L. BABBINGTON		Address BOONSBORO MD. R. 1	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident		INTERVAL BETWEEN ONSET AND DEATH 3 days	
DUE TO 422.1			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Cerebroarteriosclerosis		Years	
DUE TO			
(c) Artheriosclerotic cardiovascular disease		Years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive heart failure		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/18 , 1958, to 10/21 , 1958, that I last saw the deceased alive on 10/20 , 1958, and that death occurred at 8:15 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Hagerstown, Maryland			
ACTUAL SIGNATURE John C. Stauffer		DATE SIGNED 10/22/58	
PHYSICIAN'S NAME (Type) John C. Stauffer, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 23 1958	
22c. NAME OF CEMETERY OR CREMATORIUM LUTHERAN CEMETERY		22d. LOCATION (City, town, or county) MIDDLETON FRED.CO.MD.	
(State)		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Bost		ADDRESS Boonsboro Md.	
24a. REC'D BY REGISTRAR OCT 27 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11771 CERTIFICATE OF DEATH

11768

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		b. COUNTY Washington	
c. LENGTH OF STAY IN 1b 30 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 9 Madison Ave.	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First ELMER	Middle LEROY	Last BLESSING
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Sept. 27, 1919
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Mechanicsburg, Penna.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Elmer R. Blessing		14. MOTHER'S MAIDEN NAME Margaret Elizabeth Squibb	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Margaret Redmond		Address 9 Madison Ave. Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 605X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. 002X (b) DUE TO (c)		4 weeks Acute hemorrhagic cystitis (3 and pyelonephritis) 1 week	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour e. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-29, 1937, to 10-24, 1958, that I last saw the deceased alive on 10-24, 1958, and that death occurred at 8:05 A.M., from the causes and on the date stated above. ACTUAL SIGNATURE John H. Hornbaker M.D. ADDRESS (Street, city or town, state) 154 West Washington St., Hagerstown, Md. DATE SIGNED 10:25:58			
PHYSICIAN'S NAME (Type) John H. Hornbaker, M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/27/58	
22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc.		ADDRESS Hagerstown, Md.	
24a. REC'D BY REGISTRAR Oct. 27 '58		24b. REGISTRAR'S SIGNATURE John S. Hornbaker	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
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the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11772

CERTIFICATE OF DEATH

11769

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town) Hagerstown, Md.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown, Md.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 800 Greenbrier Rd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Gerald		First F.	Middle Blessing
4. DATE OF DEATH Oct. 17, 1958	Month Oct.	Day 17	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-21-1903
9. AGE (In years lost birthday) 54	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) General Manager		10b. KIND OF BUSINESS OR INDUSTRY Printing Co. Book Binding &	
11. BIRTHPLACE (State or foreign country) Coatsville, Pa.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME B. Franklin Blessing		14. MOTHER'S MAIDEN NAME Lucy Fourthman	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 173-03-2953	
17. INFORMANT Mrs. Lucille Margin Blessing, 800 Greenbrier Rd.		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple Myeloma</u>		INTERVAL BETWEEN ONSET AND DEATH 6 weeks	
DUE TO 205X			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 8-31-58, 19, to 10-17-58, 19, that I last saw the deceased alive on 10-17-58, 19, and that death occurred at 1:32 P. M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Paul Harrison</i>		ADDRESS (Street, city or town, state) M.D. 318 N. Potomac St. DATE SIGNED 10-18-58	
22a. PHYSICIAN'S NAME (Type) Paul Harrison, M. D.		Hagerstown, Md.	
22b. BURIAL, CREMATION, REMOVAL (Specify) Burial		22c. DATE THEREOF 10/20/58	22d. NAME OF CEMETERY OR CREMATORIUM Burns Hill
22e. LOCATION (City, town, or county) Waynesboro, Franklin Penna.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter J. Grove, Waynesboro Pa.</i>		24a. ADDRESS ADDRESS	24b. REGISTRAR'S SIGNATURE Arthur L. Traus
		24a. REC'D BY REGISTRAR DATE OCT 21 '58	24b. REGISTRAR'S SIGNATURE

87-1000008-HIGH TO STATE QUADRATIC

HIGH TO STATE QUADRATIC

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11770

11773

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown Md.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 67 Broadway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Niles	Middle Ulmont	Last Booth	4. DATE OF DEATH Oct. 9 1958	Month Oct.	Day 9	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 5, 1958	9. AGE (In years lost birthday) yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS. Days	12. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Hagerstown Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Niles James Booth				14. MOTHER'S MAIDEN NAME Betty Jane Bowers			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Niles J. Booth		Address 37 Broadway Hagerstown Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 776X DUE TO Feveraturity. INTERVAL BETWEEN ONSET AND DEATH 5 days							
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b)		DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct. 5, 1958, to Oct. 9, 1958, that I last saw the deceased alive on Oct. 5, 1958, and that death occurred at 11:50 A.M. from the causes and on the date stated above ACTUAL SIGNATURE H. Edwin Blair, M.D.		ADDRESS (Street, city or town, state) 214 North 1st Street, Hagerstown, Md.		DATE SIGNED Oct. 14, 1958			
22a. BLR AL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 10-58		22c. NAME OF CEMETERY OR CREMATORIUM Greenlawn Cemetery		22d. LOCATION (City, town, or county) (State) Williamsport, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE H. Edwin Blair, M.D.		ADDRESS 11773 Broadway		24a. REC'D BY REGISTRAR DATE OCT 14 '58		24b. REGISTRAR'S SIGNATURE Clyburn S. Krause	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11823 CERTIFICATE OF DEATH

11771

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro R.F.D. #2		c. LENGTH OF STAY IN 1b 10 Years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fahmey-Keedy Memorial Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First MARY	Middle GERTRUDE	Last BOWLUS
4. DATE OF DEATH	Month October	Day 8	Year 1958
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> April 29, 1878	9. AGE (In years last birthday) 80 yrs
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House-work		10b. KIND OF BUSINESS OR INDUSTRY At Home	11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME Franklin L. Bowlus		14. MOTHER'S MAIDEN NAME Sarah Ellen Beachley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown) No		16. SOCIAL SECURITY NO None	17. INFORMANT Emmert R. Bowlus, 610 Fairview Avenue, Frederick, Md.
18. CAUSE OF DEATH [Enter only one cause per line for part (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH 2 wks	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Coronary Atherosclerosis		5 yrs	
(c) DUE TO Essential hypertension			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Boonsboro
20f. (City or town) Boonsboro		(County) Md.	
(State) Md.			
21. I certify that I attended the deceased from January 1958 to Oct 8, 1958 , that I last saw the deceased alive on October 7, 1958 , and that death occurred at Boonsboro M, from the causes and on the date stated above			
ACTUAL SIGNATURE G. W. Willey		ADDRESS (Street, city or town, state) Boonsboro	
PHYSICIAN'S NAME (Type) G. W. Willey		DATE SIGNED 10/8/58	
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/10/58	22c. NAME OF CEMETERY OR CREMATORIY Pleasant View Cemetery	22d. LOCATION (City, town, or county) Nr. Burkittsville, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE M.R. Etchison & Son; Frederick, Maryland		24a. REC'D BY REGISTRAR DATE OCT 9 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

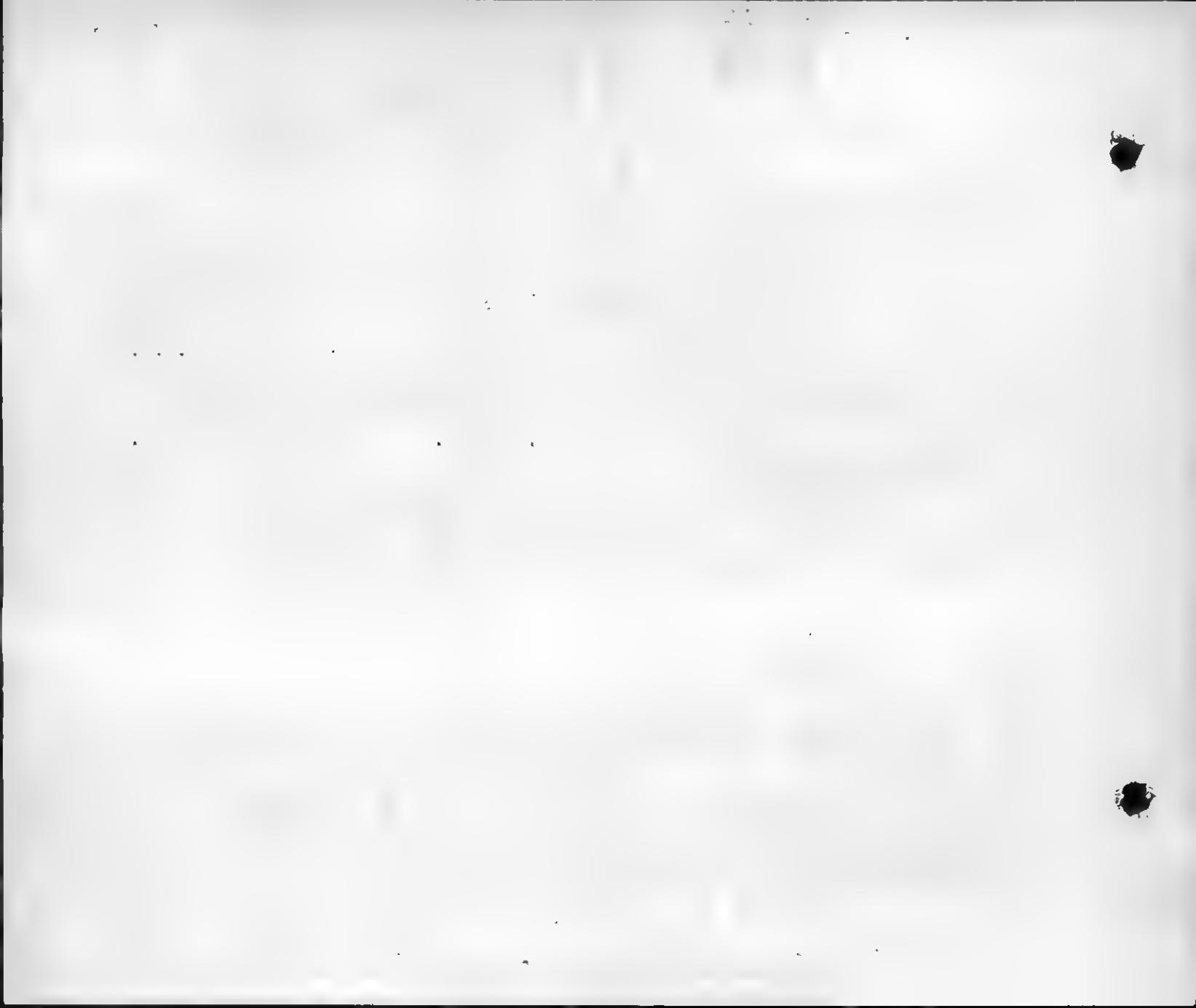
11774

CERTIFICATE OF DEATH

11772

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland		b. COUNTY Allegany		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lonaconing		d. STREET ADDRESS none		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 326 Last Franklin Street				d. STREET ADDRESS none		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First JANE	Middle ABBOTT	Last BOYD	4. DATE OF DEATH	Month October	Day 23	Year 1958	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH May 8, 1872	9. AGE (In years lost birthday) 86 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Lonaconing, Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME John Abbott		14. MOTHER'S MAIDEN NAME Jessie Brown		Address				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) No		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Anna M. Stevenson Hagerstown, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4x40.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH weeks.
						Coronary thrombosis		
						Arteriosclerotic heart disease		indefinite
						Arteriosclerosis generalized.		11
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Senile dementia						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from April , 19 58 , to 10-23 , 19 58 , that I last saw the deceased alive on 10-22-58 , 19 58 , and that death occurred at 3:45A M , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Hagerstown						
ACTUAL SIGNATURE Robert F. Keadle		DATE SIGNED 10-23-58						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/25/58		22c. NAME OF CEMETERY OR CREMATORIUM Oak Hill Cemetery		22d. LOCATION (City, town, or county) (State) Lonaconing, Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE George Eichhorn		ADDRESS Lonaconing, Md.		24a. REC'D BY REGISTRAR OCT 27 '58		24b. REGISTRAR'S SIGNATURE Arthur L. Kranz		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11775 CERTIFICATE OF DEATH

Reg. Dist. No. 302
11773

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b Life		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY Washington		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 03 Hagerstown		d. STREET ADDRESS 147 East Avenue		e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First ROSS	Middle MARIOTT	Last BRAGONIER	4. DATE OF DEATH Oct 17 1886	Month Oct	Day 9	Year 1886			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Oct. 17 1886	9. AGE (In years last birthday) 71	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 0	Days 0	Hours 0	Min. 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) sign painter		10b. KIND OF BUSINESS OR INDUSTRY self employed		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.				
13. FATHER'S NAME Wilbur J. Bragonier		14. MOTHER'S MAIDEN NAME Susan A Rowe								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unknown		16. SOCIAL SECURITY NO NONE		17. INFORMANT O. T. Kaylor Sr.		Address Hagerstown Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 581.0		DUE TO <i>hepatitis</i> <i>liver</i>		INTERVAL BETWEEN ONSET AND DEATH 4 days						
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) DUE TO <i>liver</i>		(c)		yrs						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown		(County) Hagerstown	(State) Maryland	
21. I certify that I attended the deceased from 10/5/58 , 19, to 10/9/58 , 19, that I last saw the deceased alive on 10/9/58 , 19, and that death occurred at 11 A.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Howard N. Weeks</i>						ADDRESS (Street, city or town, state) 136 N. Potomac Street			DATE SIGNED 10/10/58	
PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.										
22a. BURIAL CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/11/58		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown		(State) Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE <i>John J. Bragonier Hagerstown, Md.</i>		ADDRESS <i>John J. Bragonier Hagerstown, Md.</i>		24a. REC'D BY REGISTRAR DATE OCT 14 '58		24b. REGISTRAR'S SIGNATURE <i>Howard S. Kraus</i>				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11824 CERTIFICATE OF DEATH

11774

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Washington Co.</i>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>MARYLAND</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Hagerstown</i>		b. COUNTY <i>Carroll Co.</i>	
c. LENGTH OF STAY IN 1b <i>2 1/2 yrs.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Westminster</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) ORGANIZATION <i>Williamsport Pines, Homewood</i>		d. STREET ADDRESS / West Main St. 06-27-58	
e. DATE OF DEATH Month Day Year <i>OCT. 29 1958</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>MARGARET LILIAN BYERS</i>		4. DATE OF DEATH	
5. SEX <i>female</i>		6. COLOR CLR RACE <i>white</i>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Jan. 27 1870</i>	
9. AGE (In years last birthday) yrs. <i>88</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. US AL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>house wife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
11. BIRTHPLACE (State or foreign country) <i>Carroll Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John Thomas Gob</i>		14. MOTHER'S MAIDEN NAME <i>Berulah Shaefer</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) <i>No, b. or unknown</i>		16. SOCIAL SECURITY NO. <i>-</i>	
17. INFORMANT <i>Homewood Church Home, Hagerstown Md.</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>331X</i>		INTERVAL BETWEEN ONSET AND DEATH	
DUE TO (b) <i>Cerebral Hemorrhage</i> DUE TO (c) <i>family arterio sclerosis</i>		4 days 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>10-27-58</i> to <i>10-29-58</i> , 1958, that I last saw the deceased alive on <i>10-29-58</i> , 1958, and that death occurred <i>10-29-58</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>John Smith, M.D.</i> ADDRESS (Street, city or town, state) <i>Hagerstown, Md.</i> DATE SIGNED <i>10-31-58</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial Nov. 1, 1958</i>		22b. DATE THEREOF <i>Oct 31 1958</i>	
22c. NAME OF CEMETERY OR CREMATORIUM <i>Westminster Cemetery, West Westminster, Md.</i>		22d. LOCATION (City, town, or county) (State) <i>West Westminster, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. E. Myers, Jr., Westminster, Md.</i>		24a. REC'D BY REGISTRAR DATE OCT 31 '58	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1
 may be retained by hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be retained for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

A15 (4)
 15M 9/55



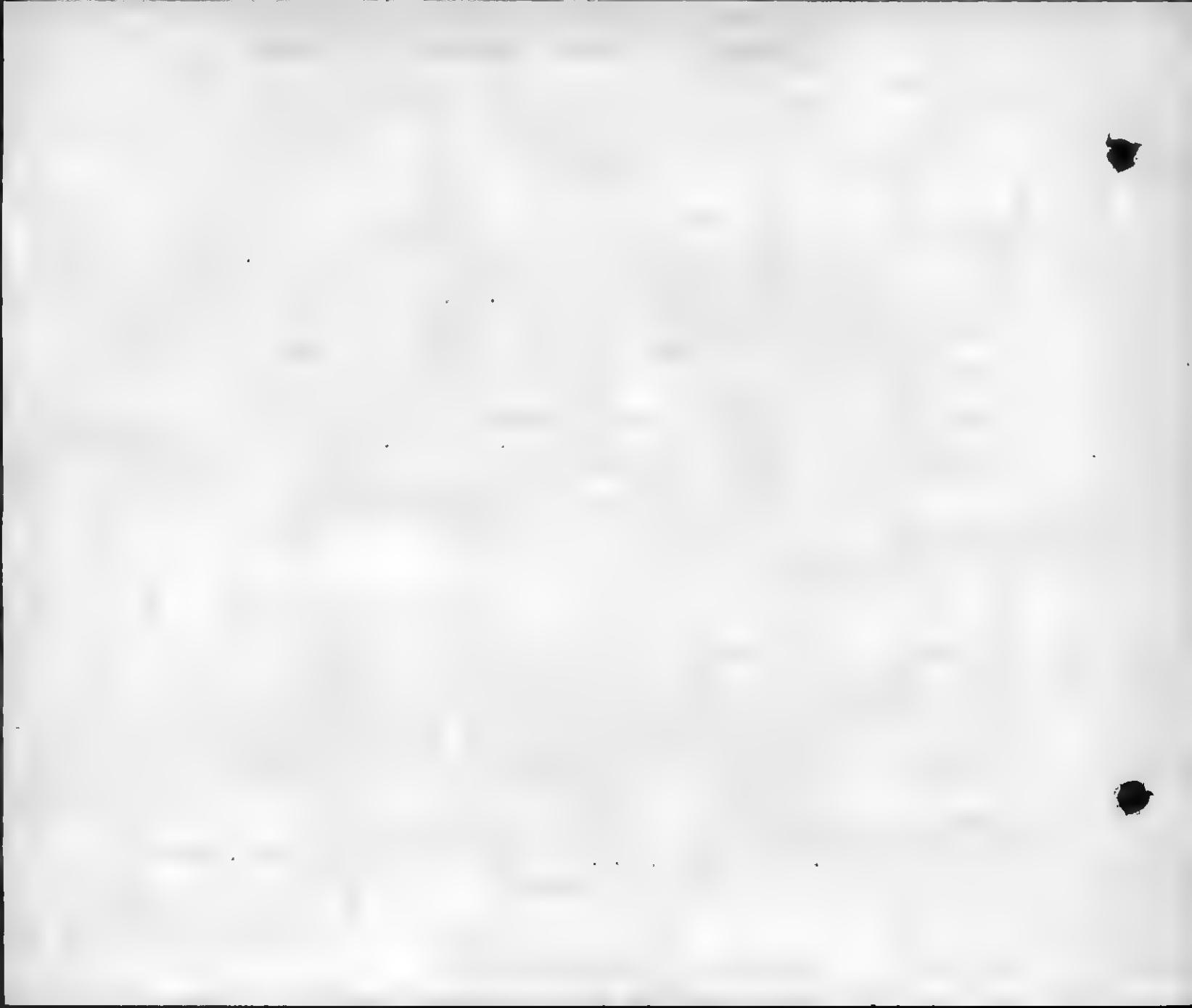
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11825 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 11775

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending", in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PHA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg		c. LENGTH OF STAY IN lb 22½ yrs	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R # 2		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg	
3. NAME OF DECEASED (Type or print) Ira Edward Carbaugh		4. DATE OF DEATH Oct. 10 1958	Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Nov. 23, 1900	9. AGE (In years last birthday) 57 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Junk Dealer		10b. KIND OF BUSINESS OR INDUSTRY Junk Business	11. BIRTHPLACE (State or foreign country) Adams Town County, Pa
13. FATHER'S NAME James Carbaugh		14. MOTHER'S MAIDEN NAME Tressa Lawna Daywalt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. -	17. INFORMANT Mrs. Thelma R. Carbaugh- Wife- Smithsburg, Md
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic coronary heart disease INTERVAL BETWEEN ONSET AND DEATH			
451 DUE TO Acute Coronary Occlusion			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) 19. WAS AUTOPSY PERFORMED? None YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. None		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None	
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year None 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none
20f. (City or town) -		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>S. Robert Wells</i>	DATE SIGNED Oct. 11 '58		
EXAMINER'S NAME (Type) S. Robert Wells, M.D.	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-14-58	22c. NAME OF CEMETERY OR CREMATORIUM Smithsburg Cemetery	22d. LOCATION (City, town, or county) Smithsburg Wash, Md
23. FUNERAL DIRECTOR'S SIGNATURE <i>Walter G. Lawna Daywalt</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE OCT 16 '58	24b. REGISTRAR'S SIGNATURE <i>Carlene S. Moore</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11826 CERTIFICATE OF DEATH

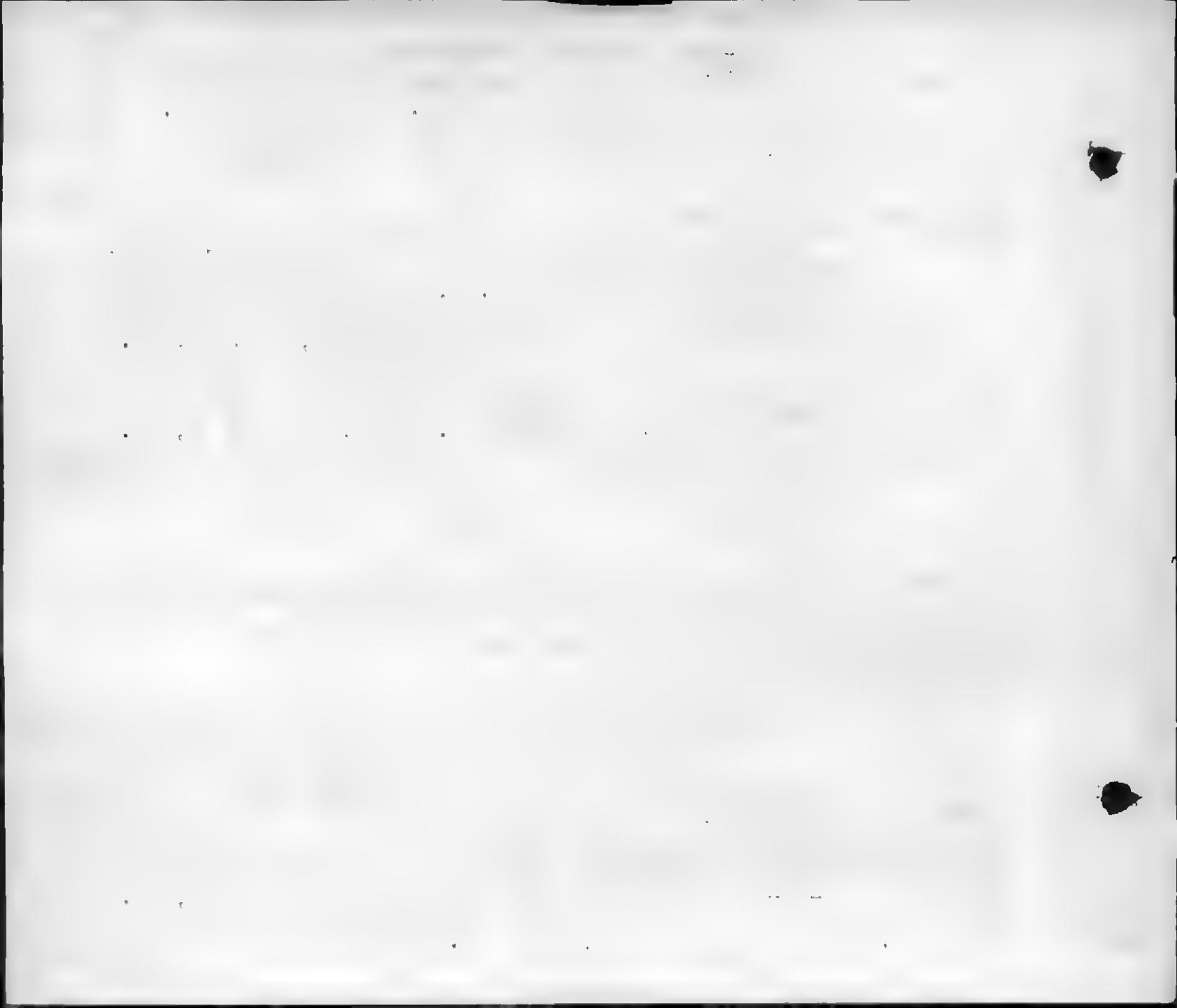
11776

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rural Smithsburg		c. LENGTH OF STAY IN 1b 50 years	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION RFD 1		d. STREET ADDRESS RFD 1	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Jacob	Middle Calvin	Last Cline
4. DATE OF DEATH	Month Oct.	Day 16, 1958	Year
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 9, 1870
9. AGE (In years lost birthday) 88 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Pleasant Valley, Wash. Co., Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Christian Cline		14. MOTHER'S MAIDEN NAME Magdalana Smith	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) no		16. SOCIAL SECURITY NO no	
17. INFORMANT Amanda M. Cline, Smithsburg, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY; IMMEDIATE CAUSE (a) 450.0		INTERVAL BETWEEN ONSET AND DEATH 5 Mo.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. (b) Generalized Arteriosclerosis		DUE TO 5 yrs.	
DUE TO Generalized Arteriosclerosis		DUE TO 5 yrs.	
DUE TO Generalized Arteriosclerosis		DUE TO 5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 6-10, 1955 to 10-16, 1958, that I last saw the deceased alive on 10-15, 1958, and that death occurred at 8 AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE Charles F. Hess		ADDRESS (Street, city or town, state) Smithsburg, Md. DATE SIGNED 10-16-58	
PHYSICIAN'S NAME (Type) Charles F. Hess M.D.			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) burial		22b. DATE THEREOF 10-18-58	
22c. NAME OF CEMETERY OR CREMATORIUM Pleasant Valley Cemetery		22d. LOCATION (City, town, or county) Smithsburg, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		24a. REC'D BY REGISTRAR OCT 20 '58	
		24b. REGISTRAR'S SIGNATURE C. F. Minnich	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

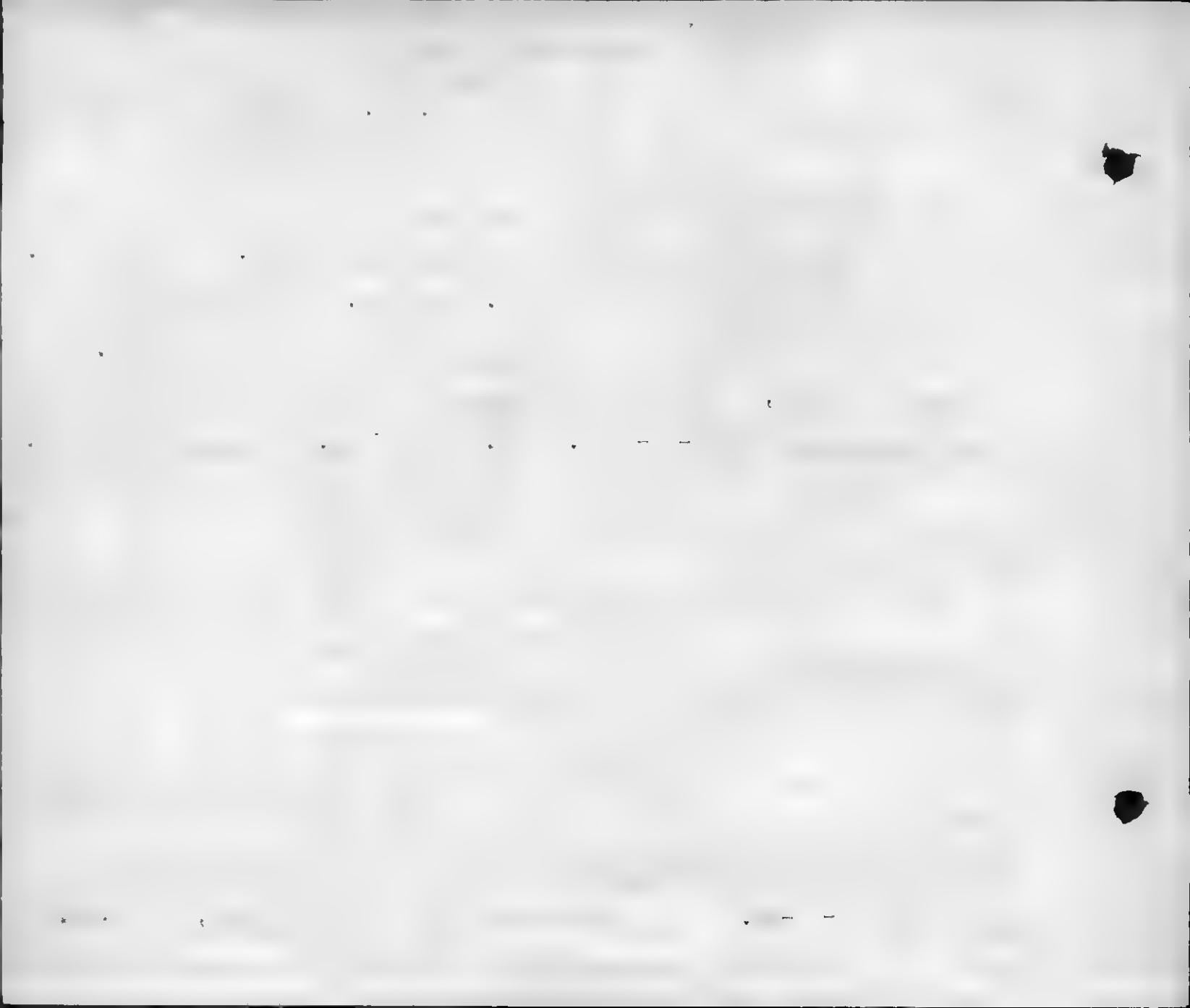
11827

CERTIFICATE OF DEATH

11777

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington County		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE W. Va.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL		c. LENGTH OF STAY IN 1b c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shepherdstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Nursing Home		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First William	Middle Franklin	Last Dailey
4. DATE OF DEATH	Month Oct.	Day 25th	Year 19 58.
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH Oct. 14th 1870.
8. BIRTHPLACE (State or foreign country) Jefferson County		9. AGE (In years last birthday) 88	10. IF UNDER 1 YEAR Months 11
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY	11. IF UNDER 24 HRS Hours 11
12. CITIZEN OF WHAT COUNTRY? USA.		13. FATHER'S NAME Richard Dailey, (dec)	
14. MOTHER'S MAIDEN NAME Charlotte Elizabeth Everhart, (dec)		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) 450.0	
16. SOCIAL SECURITY NO. 232-32-5397.		17. INFORMANT Mrs. Edward Gano.	Address Shepherdstown, W.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Chr. Cardiac Failure		INTERVAL BETWEEN ONSET AND DEATH 2 weeks	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Arterial Sclerosis		5 yrs.	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 9, 1958 to Oct 25, 1958 , that I last saw the deceased alive on Oct 24, 1958 , and that death occurred at 3:50 P.M. from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Clear Spring Md	
ACTUAL SIGNATURE David R. Brewer		DATE SIGNED 10/29/58	
PHYSICIAN'S NAME (Type) David R. Brewer			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10-28-58.	22c. NAME OF CEMETERY OR CREMATORIUM Edge Hill	22d. LOCATION (City, town, or county) Charles Town, W. Va.
23. FUNERAL DIRECTOR'S SIGNATURE M. T. Strider Co., Fairfix Blvd., Charlestown, W. Va.		24a. REC'D BY REGISTRAR NOV 5 '58	24b. REGISTRAR'S SIGNATURE Arthur E. Kaus



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11778

Reg. Dist. No.

11776

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 10 hrs		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Penna b. COUNTY Fulton				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Crystal Spring		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) William Herbert Decker		First William	Middle Herbert	Last Decker	4. DATE OF DEATH May 19, 1915	Month October	Day 7	Year 1958		
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH May 19, 1915	9. AGE (In years last birthday) 43 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0	13. CITIZEN OF WHAT COUNTRY? USA	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic		10b. KIND OF BUSINESS OR INDUSTRY Auto truck		11. BIRTHPLACE (State or foreign country) Fulton County, Pa		12. FATHER'S NAME Riley B. Decker				
13. MOTHER'S NAME Bertha Mann		14. MOTHER'S MAIDEN NAME Dorey May Decker		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 204-01-6055		17. INFORMANT Dorey May Decker		Address Crystal Springs, Pa
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fractured Skull - hemorrhage and shock		INTERVAL BETWEEN ONSET AND DEATH 65 hrs						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 825X		DUE TO (b)								
		DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) Driver of car that hit a telephone pole								
20c. TIME OF INJURY Hour 5		Month, Day, Year a. m. Oct. 5 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway		20f. (City or town) Rural -Warfordsburg,		
								(County) Pa.		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input checked="" type="checkbox"/> .										
ACTUAL SIGNATURE S. Robert Wells		EXAMINER'S NAME (Type) S. Robert Wells, M.D.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED October 8 '58
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 10, 1958		22c. NAME OF CEMETERY OR CREMATORIUM Jerusalem Cemetery		22d. LOCATION (City, town, or county) Amaranth		(State) Fulton Penna.		
23. FUNERAL DIRECTOR'S SIGNATURE Wilmer Sipes		ADDRESS Harrisonville Pa.		24a. REC'D BY REGISTRAR DATE OCT 14 '58		24b. REGISTRAR'S SIGNATURE John J. Hall				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11779

11777 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Pennsylvania b. COUNTY York	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Martin Manor Nursing Home		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) York	
3. NAME OF DECEASED (Type or print) MELLIE		First MELLIE	Middle CORA
		Last DELANO	4. DATE OF DEATH October
		Month	Day
		Year	1958
5. SEX Female		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> October 7, 1875
		8. AGE (In years last birthday) 83 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) York, Pennsylvania	
13. FATHER'S NAME Adam Hester Tchop		14. MOTHER'S M AIDEN NAME Unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) 10		16. SOCIAL SECURITY NO none	
17. INFORMANT Mr. Willia. Carbaugh Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		DUE TO Arteriosclerotic heart disease with cardiac decompensation INTERVAL BETWEEN ONSET AND DEATH 1-2 yrs.	
(b) DUE TO COPD		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 420.0 Pneumonia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 15, 1958, to Oct 9, 1958, that I last saw the deceased alive on Oct 8, 1958, and that death occurred at 11 AM, from the causes and on the date stated above. ACTUAL SIGNATURE Edward W. Datto M.D. 212 W. Washington St. 10/9/58		ADDRESS (Street, city or town, state) Edward W. Datto M.D. Hagerstown, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/11/1958	
22c. NAME OF CEMETERY OR CREMATORIAL Mt. Rose Cemetery		22d. LOCATION (City, town, or county) York	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Houzer Funeral Home O Franklin L. Hager		24a. REC'D BY REGISTRAR DATE OCT 14 '58	
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11778

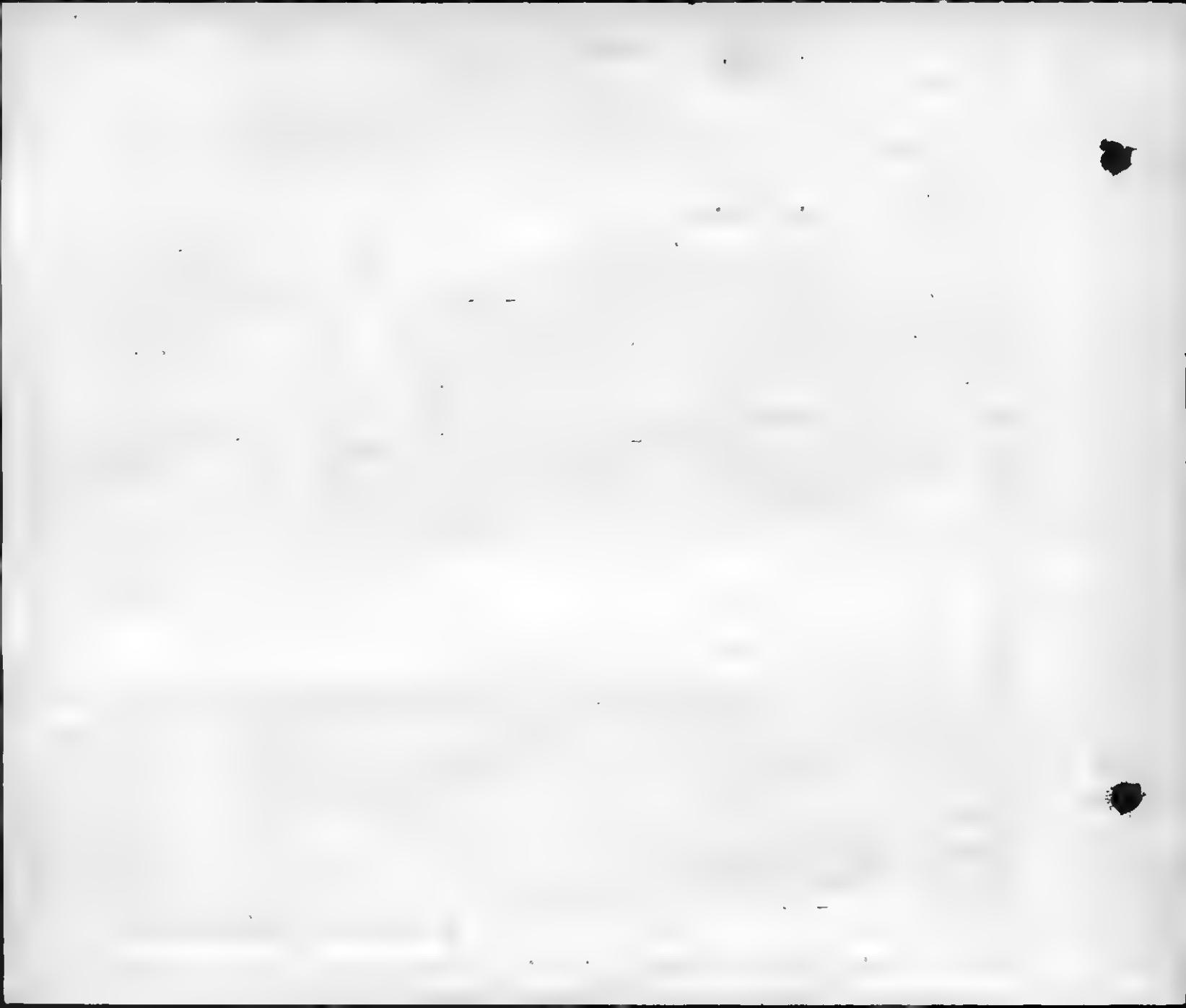
CERTIFICATE OF DEATH

11780

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE Maryland b. COUNTY Frederick	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 2 weeks Cullen X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hosp.		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Edith May Dingle		First	Middle
		Lost	4. DATE OF DEATH
		Month	Day
		Year	58
S. SEX female	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-11-1900
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	11. BIRTHPLACE (State or Foreign country) Maryland
13. FATHER'S NAME unknown		14. MOTHER'S MAIDEN NAME Sadie Kurtz	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> NO		16. SOCIAL SECURITY NO. 17. INFORMANT 179-30-4696 Benjamin Dingle	Address Cullen Maryland
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH 5 Days	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		Cerebral Hemorrhage	
(b) DUE TO		Generalized Arteriosclerosis	
(c)		5 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 10-6, 1958 to 10-10, 1958, that I last saw the deceased alive on 10-9, 1958, and that death occurred at 6 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 5th Street, theburg, Md. DATE SIGNED ACTUAL SIGNATURE Charles S. Hess			
PHYSICIAN'S NAME (Type) Charles Hess			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10-12-58	22c. NAME OF CEMETERY OR CREMATORIUM Bethel Cemetery
23. FUNERAL DIRECTOR'S SIGNATURE Raymond E. Creager		ADDRESS Thurmont, Md.	24a. REC'D BY REGISTRAR DATE Oct 14 58
			24b. REGISTRAR'S SIGNATURE Charles S. Hess

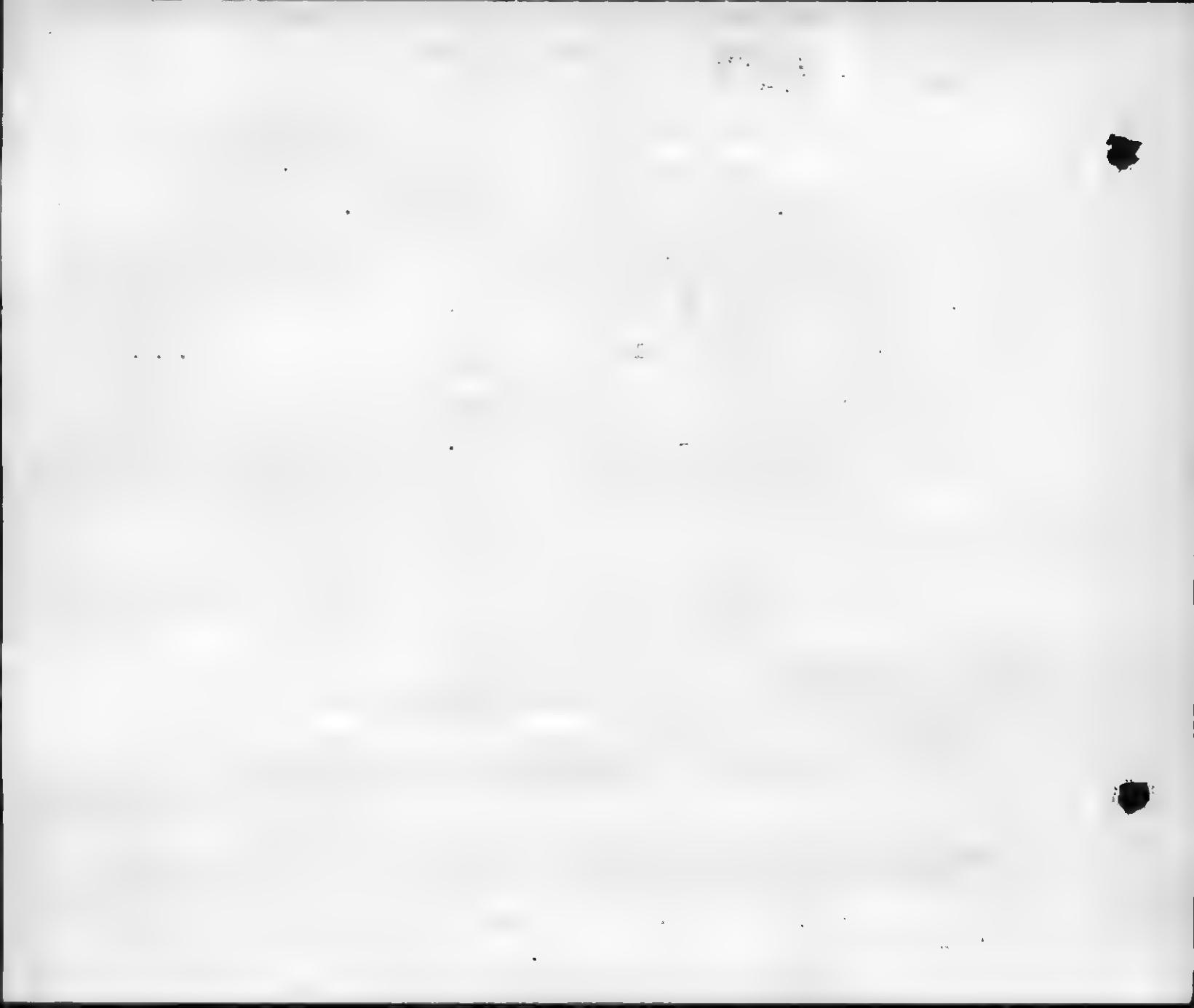
TO HOSPITAL OR ATTEN. PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 1
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



11779 CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Pennsylvania b. COUNTY Philadelphia	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 months	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 929 Hamilton Blvd.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Drexel Hill, Philadelphia	
3. NAME OF DECEASED (Type or print) PATRICK		d. STREET ADDRESS 615 Turner Ave.	
4. DATE OF DEATH October 23 1958		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH July 12, 1880	
WIDOWED <input checked="" type="checkbox"/>		9. AGE (In years last birthday) 78 yrs.	
DIVORCED <input type="checkbox"/>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Gardener	
11b. KIND OF BUSINESS OR INDUSTRY Self Employed		11. BIRTHPLACE (State or foreign country) County Tipperary, Ireland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME William Dohohue		14. MOTHER'S MAIDEN NAME Mary Grady	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 182-26-6192	
17. INFORMANT Edward J. Donohue		Address Hagerstown, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 150X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 9 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m.		Month, Day, Year 19	
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) Havertown		(County) (State) Pennsylvania	
21. I certify that I attended the deceased from <u>May 6, 1958</u> to <u>Oct 23, 1958</u> , that I last saw the deceased alive on <u>Oct 23, 1958</u> , and that death occurred at <u>4:39 PM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE <u>Paul Harrison</u> ADDRESS (Street, city or town, state) M.D. 318 N. Potomac St. DATE SIGNED 10-24-58			
22a. PHYSICIAN'S NAME (Type) Paul Harrison, M. D.		Hagerstown, Md.	
22b. BURIAL/CREMATION, REMOVAL (Specify) Burial		22c. DATE THEREOF 10/29/58	
22d. NAME OF CEMETERY OR CREMATORIUM St. Dennis Cemetery		22d. LOCATION (City, town, or county) (State) Havertown Pennsylvania	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home R. J. Harrison, Moyer		24a. REC'D BY REGISTRAR DATE OCT 27 '58	
ADDRESS Hagerstown, Md.		24b. REGISTRAR'S SIGNATURE C. S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11828 CERTIFICATE OF DEATH

11782

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington County		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clear Spring, Maryland		c. LENGTH OF STAY IN lb Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Clear Spring, Maryland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Clear Spring, Maryland				d. STREET ADDRESS Clear Spring, Maryland		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) John		First Middle John Coffman		Last Downs		4. DATE OF DEATH October 27th 1958	Month Day Year
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> May 12, 1866		9. AGE (In years lost birthday) 92 yrs	
10a. US/JAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Retired Storekeeper		11. BIRTHPLACE (State or foreign country) Downsville, Maryland		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Lewis O. Downs				14. MOTHER'S MAIDEN NAME Maria Downey			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT John L. Downs		Address Clear Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Coronary artery occlusion with myocardial infarction				INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		Hypertensive arteriosclerotic heart disease				unknown	
DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 475X Pneumonitis, acute						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour e. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Clear Spring	(County) (State)
21. I certify that I attended the deceased from October 19, 1958, to October 27, 1958, that I last saw the deceased alive on October 27, 1958, and that death occurred at 4:25 P.M., from the causes and on the date stated above. ACTUAL SIGNATURE <i>Archie Robert Cohen</i> M.D.						ADDRESS (Street, city or town, state) DATE SIGNED	
PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.				Clear Spring, Maryland		Oct. 27, 1958	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 30, 1958		22c. NAME OF CEMETERY OR CREMATORIUM St Paul Cemetery		22d. LOCATION (City, town, or county) Near Clear Spring, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John F. Linnane</i>		ADDRESS Clear Spring, Maryland		24a. REC'D BY REGISTRAR DATE OCT 31 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11780

CERTIFICATE OF DEATH

11783

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 68 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 21 E Washington Street		d. STREET ADDRESS 31 E. Washington Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) GEORGE	First	Middle	Last	4. DATE OF DEATH Oct. 30 1958	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Dec 26 1878	9. AGE (In years last birthday) 79 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) R.R. Conductor		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (State or foreign country) W. Va		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Norman Fisher		14. MOTHER'S MAIDEN NAME Margaret Fayman					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO. 705-10-5343		17. INFORMANT Mrs. Mary Daugherty		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastric carcinoma of left lung DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)	
						INTERVAL BETWEEN ONSET AND DEATH 2 days	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f (City or town) (County) (State)			
21. I certify that I attended the deceased from 10/26/1878 , 19 58 , to 10/31/1878 , 19 58 , that I last saw the deceased alive on 10/26/1878 , 19 58 , and that death occurred at 12 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 145 S. Prospect St. DATE SIGNED 10/31/1878							
ACTUAL SIGNATURE <i>John C. Stauffer</i>		M.D.					
PHYSICIAN'S NAME (Type) John C. Stauffer, M.D.		Hagerstown, Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/1/58		22c. NAME OF CEMETERY OR CREMATORIUM Christ Reformed Cemetery		22d. LOCATION (City, town, or county) Shepherdstown W. Va. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE S. H. H. H.		ADDRESS Hagerstown Md		24a. REC'D BY REGISTRAR NOV 3 1958		24b. REGISTRAR'S SIGNATURE C. H. S. K. and	
				DATE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by _____ hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit Permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. LeVan

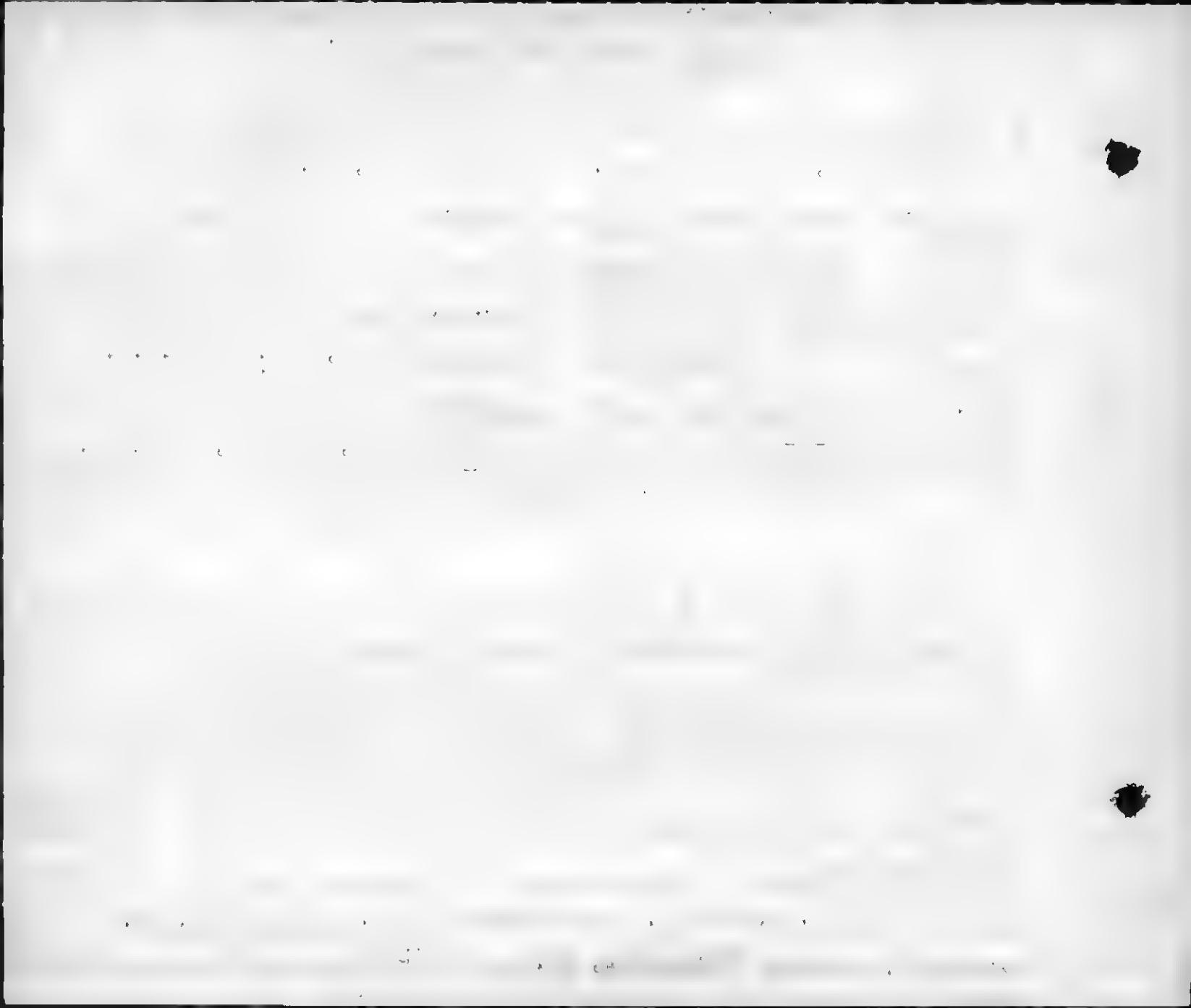
11784

11829 CERTIFICATE OF DEATH

Reg. Dist. No.

302

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro, Md. # 3		c. LENGTH OF STAY IN 1b 5 yrs.		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		b. COUNTY Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro, Md. # 3		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION San-Mar Road		d. STREET ADDRESS San-Mar Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print) John		First Albert		Middle Funkhouser		4. DATE OF DEATH October 5 1958		Month Day Year				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 5, 1868		9. AGE (In years last birthday) 89 yrs		10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0	12. IF UNDER 24 HRS Hours 0	13. CITIZEN OF WHAT COUNTRY? U. S. A.	14. MOTHER'S MAIDEN NAME Mary Jane Steele	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) Indian Spring, Wash. Cty		12. CITIZEN OF WHAT COUNTRY? U. S. A.						
13. FATHER'S NAME V. Godfrey Funkhouser		14. MOTHER'S MAIDEN NAME Mary Jane Steele		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Mamie Sites, Boonboro, Md. # 3, Md.		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		19. INTERVAL BETWEEN ONSET AND DEATH 10 yrs
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Boonboro		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
21. I certify that I attended the deceased from Sept. 5, 1958 to October 5, 1958 , that I last saw the deceased alive on October 4, 1958 , and that death occurred at 5 A. M. from the causes and on the date stated above. ACTUAL SIGNATURE G. W. LeVan		ADDRESS (Street, city or town, state) Boonboro		DATE SIGNED 10/6/58								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 8, 1958		22c. NAME OF CEMETERY OR CREMATORIUM St. Pauls Cemetery		22d. LOCATION (City, town, or county) nr. Clearspring, Md.		(State)				
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Md.		ADDRESS		24a. REC'D BY REGISTRAR Arthur S. Krause		24b. REGISTRAR'S SIGNATURE						
VS AIS (4) 15M 9/55		DATE OCT 9 '58										



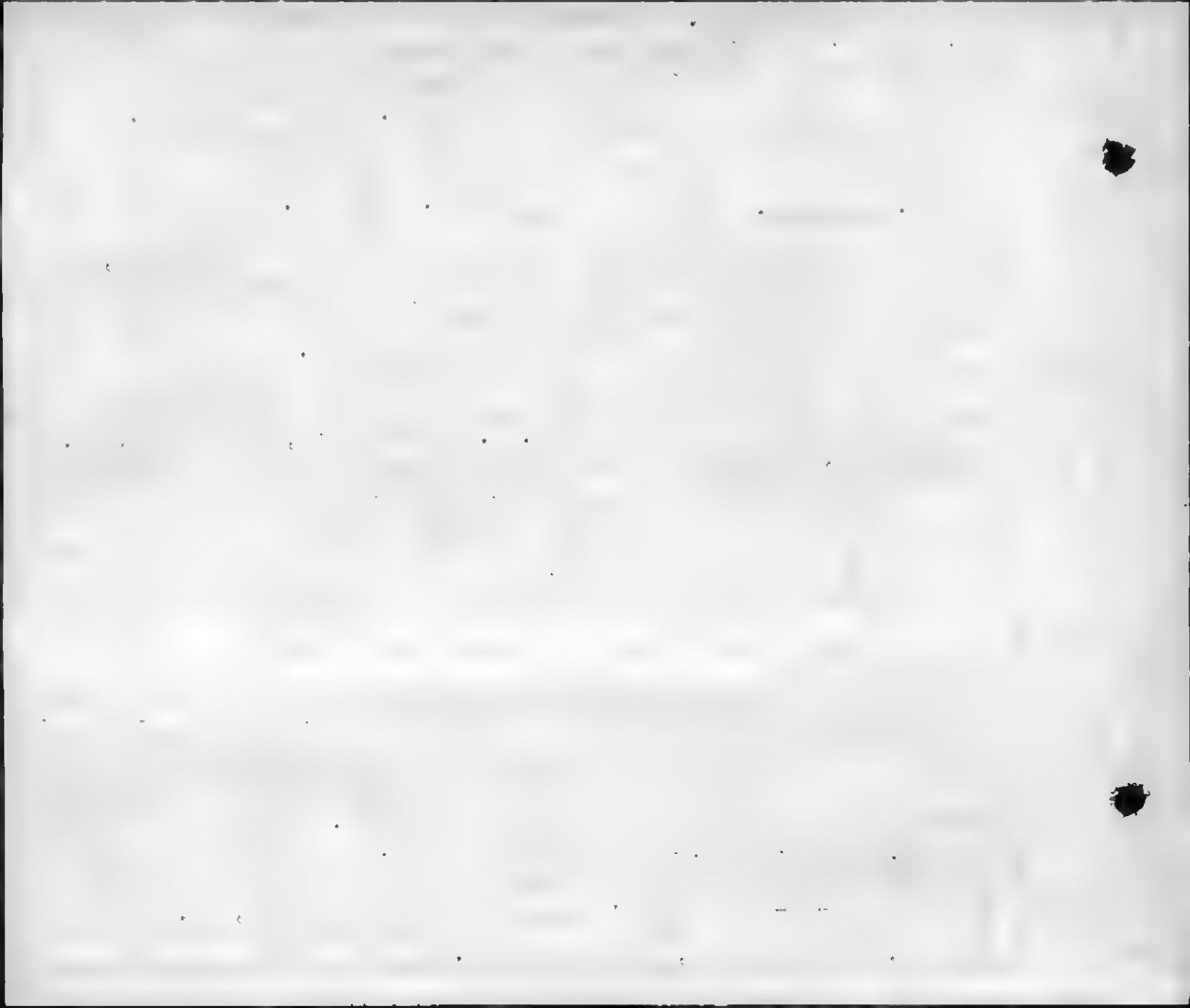
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11785

Reg. Dist. No.

Dr. George A. Kohler
Family physician ill 11830 CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Wash.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg		c. LENGTH OF STAY IN 1b life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 55 W. Water St.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Smithsburg			
3. NAME OF DECEASED (Type or print) First Virgin Middle Elizabeth Last Geiser		4. DATE OF DEATH Month October 18, 1958 Day Year			
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 15, 1884		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or Foreign country) Smithsburg, Md.		
13. FATHER'S NAME Samuel Geiser		14. MOTHER'S MAIDEN NAME Elizabeth Stoner			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	17. INFORMANT Mrs. D. Yulee Huyett, Smithsburg, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		INTERVAL BETWEEN ONSET AND DEATH 7 hours Occlusion Coronary Occlusion			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteris Sclerosis		DUE TO			
(c) Cardiac Decomposition		DUE TO			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) None			
20c. TIME OF INJURY Month, Day, Year Hour a. m. None 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) None	20f. (City or town) —	(County) —	(State) —
21. I certify that I attended the deceased from <u>June 10</u> , 1956, to <u>Oct 18</u> , 1958, that I last saw the deceased alive on <u>Oct 18</u> , 1958, and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. <u>115 N. Potomac St</u> DATE SIGNED <u>S. Robert Wells</u> <u>10-21-58</u>					
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) <u>S. Robert Wells, M.D.</u> D.M.E. Washington County, Md Hagerstown Md					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial	22b. DATE THEREOF 10-21-58	22c. NAME OF CEMETERY OR CREMATORIAL Welty's Cemetery	22d. LOCATION (City, town, or county) Greensburg, Md.	(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Smithsburg, Md.		ADDRESS	24a. REC'D BY REGISTRAR DATE Oct 22, 1958	24b. REGISTRAR'S SIGNATURE G. H. F. H.	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11786

11831 CERTIFICATE OF DEATH

Reg. D(st. No.)

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION REEDER NURSING HOME		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First GRACE	Middle ANN	Last GORDON
4. DATE OF DEATH	Month October	Day 7	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> March 24, 1890
9. AGE (In years from birthday) 68 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Sandy Hook, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Nicholas Powers		14. MOTHER'S MAIDEN NAME Margaret Ellen Frances Barger	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. Margaret E. Hartman Address 5701 71st Place, West Hyattsville, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gastroesophageal reflux disease</i> DUE TO <i>Diabetes</i> INTERVAL BETWEEN ONSET AND DEATH 3 yrs. Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) (c) 6 yrs. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 14, 1958</i> to <i>Oct 14, 1958</i> that I last saw the deceased alive on <i>Oct 14, 1958</i> , and that death occurred at <i>Boonsboro</i> , M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) Boonsboro, Md. DATE SIGNED <i>Boonsboro, Md.</i> 10/14/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/10/58	
22c. NAME OF CEMETERY OR CREMATORIAL Reformed Cemetery		22d. LOCATION (City, town, or county) (State) Knoxville, Maryland	
23. FUNERAL DIRECTIONS SIGNATURE <i>Donald Sackles</i>		24a. ADDRESS Harpers Ferry, West Va.	
		24b. REG'D. BY REGISTRAR OCT 14 1958	
		24b. REGISTRAR'S SIGNATURE <i>Mary E. Hartman</i>	



H

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be rejoined to the hospital or attending physician.

154 W. WASH. ST.
Boonsboro MD.

DR. JOHN H. HORNBAKER

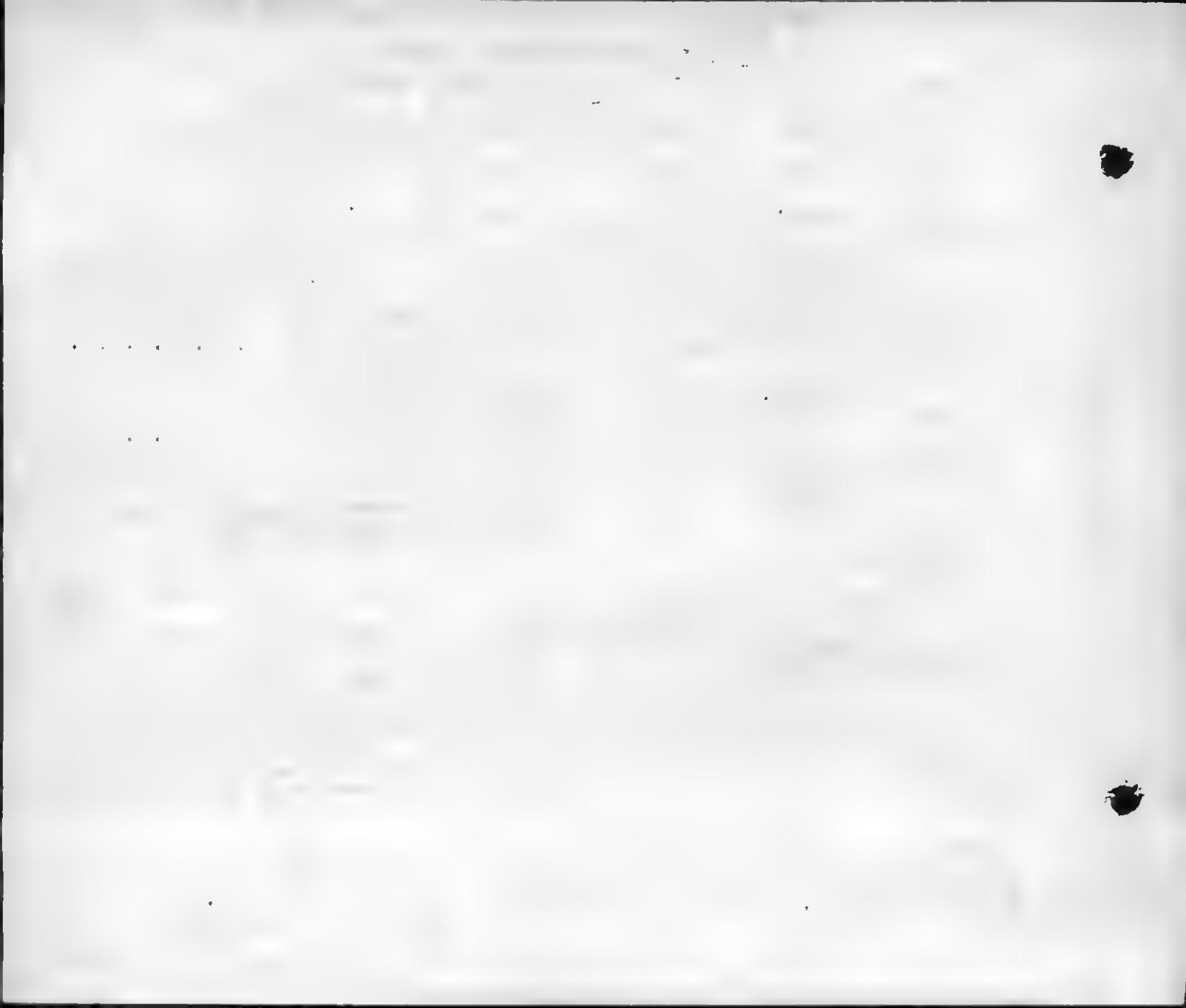
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11832 CERTIFICATE OF DEATH

11787

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) APPLETOWN RURAL		b. COUNTY WASHINGTON		
c. LENGTH OF STAY IN 1b 48 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X APPLETOWN RURAL		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION BOONSBORO MD. ROUTE 2		d. STREET ADDRESS BOONSBORO MD. ROUTE 2		
3. NAME OF DECEASED (Type or print) eva		First nicodemus	Middle green	
4. DATE OF DEATH OCTOBER 17 1958	Month 10	Day 17	Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED	9. AGE (in years last birthday) NOVEMBER 30	
		8. DIVORCED <input type="checkbox"/>	10. IF UNDER 1 YEAR Months 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	11. BIRTHPLACE (State or foreign country) NEAR BOONSBORO WASH. D. C. MD. U. S. A.	
13. FATHER'S NAME MARTIN R. NICODEMUS		14. MOTHER'S MAIDEN NAME ELLEN HUFF R		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO	16. SOCIAL SECURITY NO.	17. INFORMANT MISS MILDRED GALEN BOONSBORO M.R.1	Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Pulmonary tuberculosis, far advanced</i>			INTERVAL BETWEEN ONSET AND DEATH 25 years	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Carcinoma of breast</i>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Hour o. m. p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) 154 W. Washington St.	(County) Hagerstown (State) MD.
21. I certify that I attended the deceased from 10-14, 1958 to 10-17 1958 , that I last saw the deceased alive on 10-14, 1958 , and that death occurred at 6:40 A.M. from the causes and on the date stated above.				
ACTUAL SIGNATURE <i>John H. Hornbaker</i>	ADDRESS (Street, city or town, state) Hagerstown - Md.			DATE SIGNED 10-18-58
PHYSICIAN'S NAME (Type) JOHN H. HORNBAKER				
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION	22b. DATE THEREOF OCT. 19 1958	22c. NAME OF CEMETERY OR CREMATORIUM BOONSBORO CEMETERY	22d. LOCATION (City, town, or county) BOONSBORO MD.	(State)
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Bost</i>	ADDRESS Boonsboro Md.	24a. REC'D BY REGISTRAR DATE OCT 22 '58	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

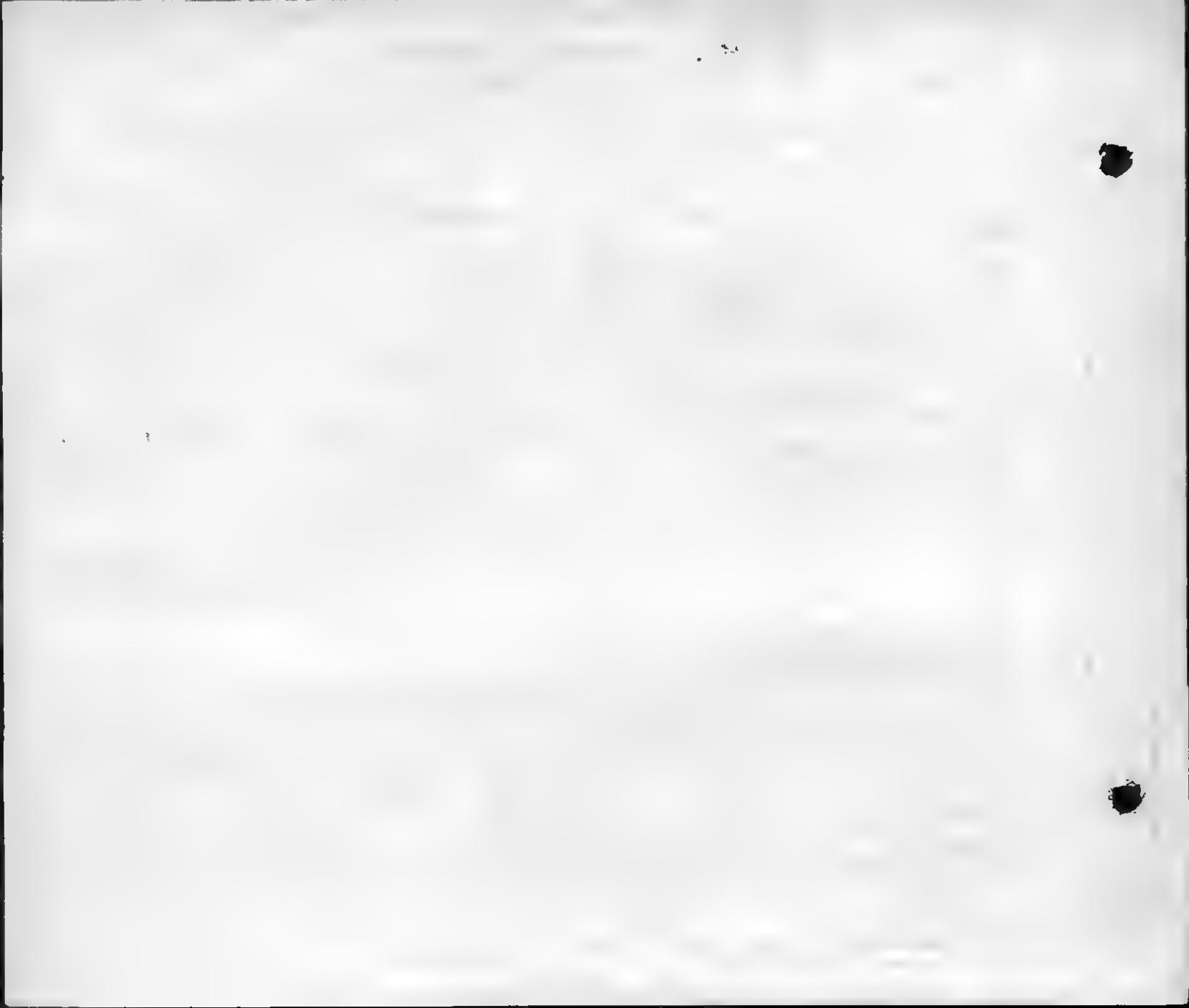
11781

CERTIFICATE OF DEATH

11788

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Hagerstown		c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 266 Frederick St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			
3. NAME OF DECEASED (Type or print) MARY		First MIDDLE BELLE	Last GROSS		
4. DATE OF DEATH Oct.	Month Oct.	Day 24	Year 1958		
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Oct. 25, 1888	9. AGE (in years last birthday) 69 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (State or foreign country) Washington County, Md.	
13. FATHER'S NAME Benjamin Jacob Knodle		14. MOTHER'S MAIDEN NAME Laura		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no, or unknown)		16. SOCIAL SECURITY NO None	17. INFORMANT Mrs. Roy Smith 266 Frederick St. Hagerstown, Md.	Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma Pt. Breast, generalized metastasis</i>				INTERVAL BETWEEN ONSET AND DEATH 2 yrs +	
170 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Nat white <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) M. D. 231 N Potomac	(County) (State) Hagerstown Md.
21. I certify that I attended the deceased from <i>10/10/58</i> , 1958, to <i>24 Oct</i> , 1958, that I last saw the deceased alive on <i>23 Oct</i> , 1958, and that death occurred at <i>10 A</i> M, from the causes and on the date stated above. ACTUAL SIGNATURE <i>F. F. Lusby</i> ADDRESS <i>231 N Potomac</i> DATE SIGNED <i>25 Oct 58</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/27/58	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc.		ADDRESS Hagerstown, Md.	24a. REC'D BY REGISTRAR DATE <i>OCT 27 58</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11789

11782 CERTIFICATE OF DEATH

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)				
Washington MARYLAND		a. STATE Pennsylvania b. COUNTY Franklin				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN lb	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)				
Hagerstown	3 days	d. STREET ADDRESS Route #3				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print)	First Katie	Middle S.	Last Grove			
4. DATE OF DEATH	Month October	Day 1	Year 1958			
5. SEX	6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/3/1891	9. AGE (in years at time of death) 66 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY House work		11. BIRTHPLACE (State or foreign country) Washington & Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Michael Eshleman		14. MOTHER'S MAIDEN NAME Amanda Stife				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Luther Stone, R.R. #3 Greencastle		Address
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Cerebral Thrombosis			4 hrs	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		Arteriosclerosis			2 yrs	
DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the under- lying cause first.		Diabetes Mellitus			5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		Myocardial Infarction - 5 days.			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Hour a. m. p. m.		Month 19	Day Not while at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 214 N Potomac St	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept 28, 1958, to Oct 1, 1958, that I last saw the deceased alive on Oct 1, 1958, and that death occurred at 9:00 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 214 N Potomac St 10/1/58 DATE SIGNED						
ACTUAL SIGNATURE Lloyd A. Hoffman	PHYSICIAN'S NAME (Type) Lloyd A. Hoffman		Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/5/1958	22c. NAME OF CEMETERY OR CREMATORIAL Cedar Grove Moravite Cem. Antietam Twp. Franklin Co. Penn	22d. LOCATION (City, town, or county) (State) Franklin Co. Penn			
23. FUNERAL DIRECTOR'S SIGNATURE Harold M. Zimmerman, Greencastle, Pa.		ADDRESS	24a. REC'D BY REGISTRAR DATE OCT 6 '58	24b. REGISTRAR'S SIGNATURE C. Lee S. Kraus		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

ITEMS 11-312 E-1-222 11-1-28 e

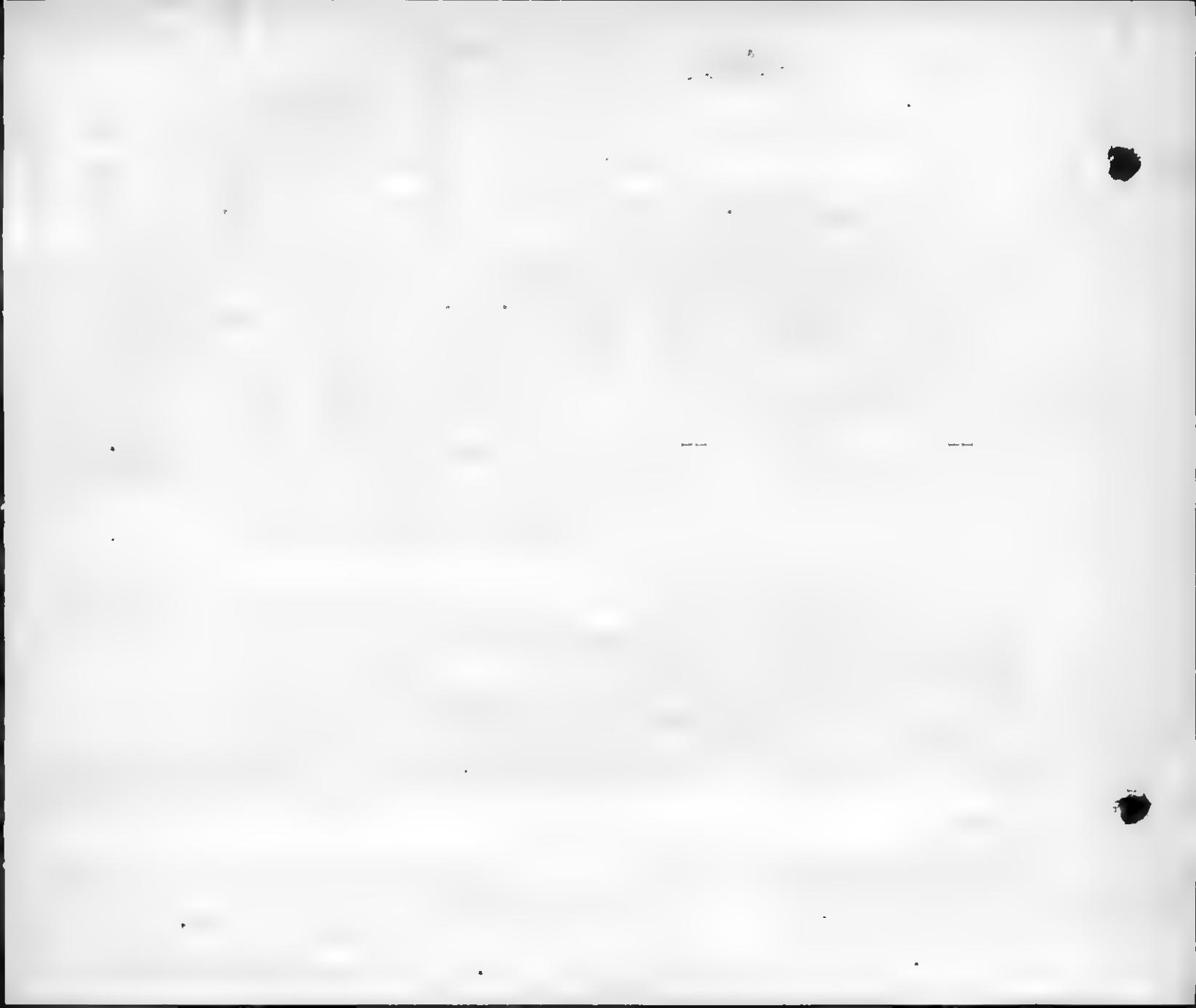
11783

CERTIFICATE OF DEATH

Reg. Dist. No 1

11790

1. PLACE OF DEATH a. COUNTY Washington			2. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) a. STATE Maryland		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 709 Marshall St.			e. STREET ADDRESS 709 Marshall St.		
3. NAME OF DECEASED (Type or print) Minerva			First May	Middle Grove	Last
4. DATE OF DEATH October			Month	Day	Year 29 19 58
5. SEX Female			6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25, 1875
9. AGE (In years last birthday) 83 yrs.			10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) Mapleville, Maryland
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME Silas Foltz			14. MOTHER'S MAIDEN NAME Mary Ellen Welty		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) and date			16. SOCIAL SECURITY NO. 17. INFORMANT Address Mrs. Mary Price Hagerstown Md.		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 170 X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. DUE TO (b) DUE TO (c) Malnutrition Carcinoma of l. breast			INTERVAL BETWEEN ONSET AND DEATH 3-4 WKS 2 years		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Generalized degeneration			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)			20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from _____, 1954 to _____, death, that I last saw the deceased alive on _____, and that death occurred on _____, 1954, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE Robert F. Keadle, M. D. 318 N. Potomac St., Hagerstown, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 11-1-58		
22c. NAME OF CEMETERY OR CREMATORIAL Reformed Cemetery			22d. LOCATION (City, town, or county) Cavetown Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son			24a. REC'D BY REGISTRAR DATE NOV 3 '58		
ADDRESS Hagerstown Md.			24b. REGISTRAR'S SIGNATURE Arthur S. Keadle		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

ITEM 12, 13, 14 FILE 22 11-5-28 81

11791

11784

CERTIFICATE OF DEATH

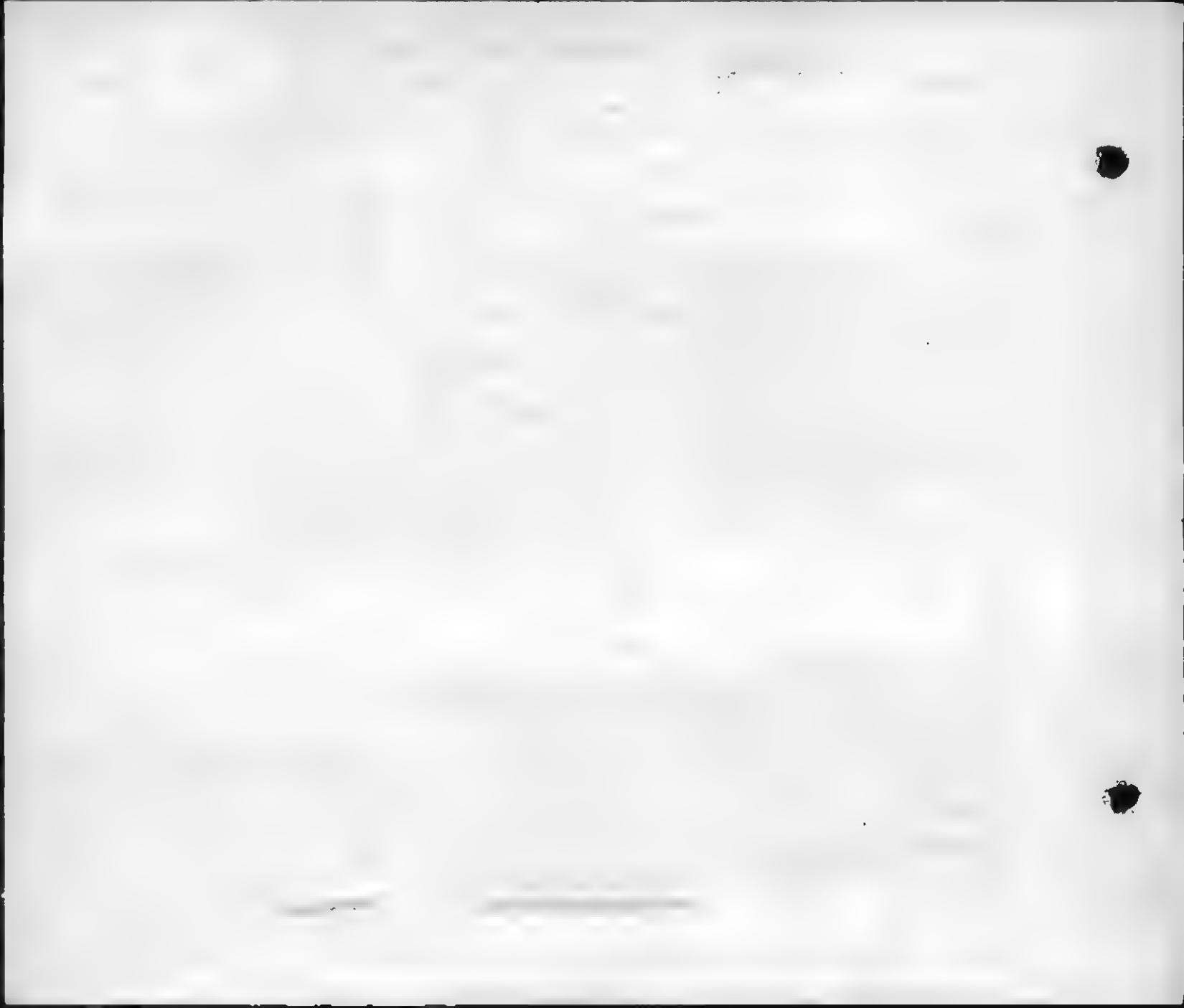
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON			2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			c. LENGTH OF STAY IN 1b 1 DAY					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WESTERN MARYLAND STATE HOSPITAL			e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BALTIMORE					
3. NAME OF DECEASED (Type or print) PAUL			d. STREET ADDRESS 819 WOODROW AVE.					
First PAUL		Middle HANSON	4. DATE OF DEATH OCTOBER 29 1958	Month OCTOBER	Day 29			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH OCTOBER 15, 1881	9. AGE (In years last birthday) 77	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Year 1958	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) BLACKSMITH			10b. KIND OF BUSINESS OR INDUSTRY SWEDEN			11. BIRTHPLACE (State or foreign country) SWEDEN		
13. FATHER'S NAME Unknown			14. MOTHER'S MAIDEN NAME Unknown			12. CITIZEN OF WHAT COUNTRY? Unknown		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.			17. INFORMANT Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TERMINAL BRONCHO-PNEUMONIA DUE TO 352X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b). DUE TO CEREBRAL THROMBOSIS 4 MONTHS								
DUE TO 493X PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) DUE TO ARTERIOSCLEROSIS, GENERAL UNKNOWN								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from OCT. 28, 1958 to OCT. 29, 1958 , that I last saw the deceased alive on OCT. 29, 1958 , and that death occurred at 1:25 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 1500 PENNSYLVANIA AVE. DATE SIGNED 10/29/58								
ACTUAL SIGNATURE George Beren			PHYSICIAN'S NAME (Type) DR. GEORGE BEREN					
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal			22b. DATE THEREOF 10/30/58			22c. NAME OF CEMETERY OR CINERARY CHAMBERSBURG MD		
23. FUNERAL DIRECTOR'S SIGNATURE 715 Leithman			ADDRESS Hagerstown MD			24a. REC'D BY REGISTRAR DATE OCT 31 '58		
24b. REGISTRAR'S SIGNATURE Carrie S. Kraus								

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed.

VS A1S (4)
15M 9/55



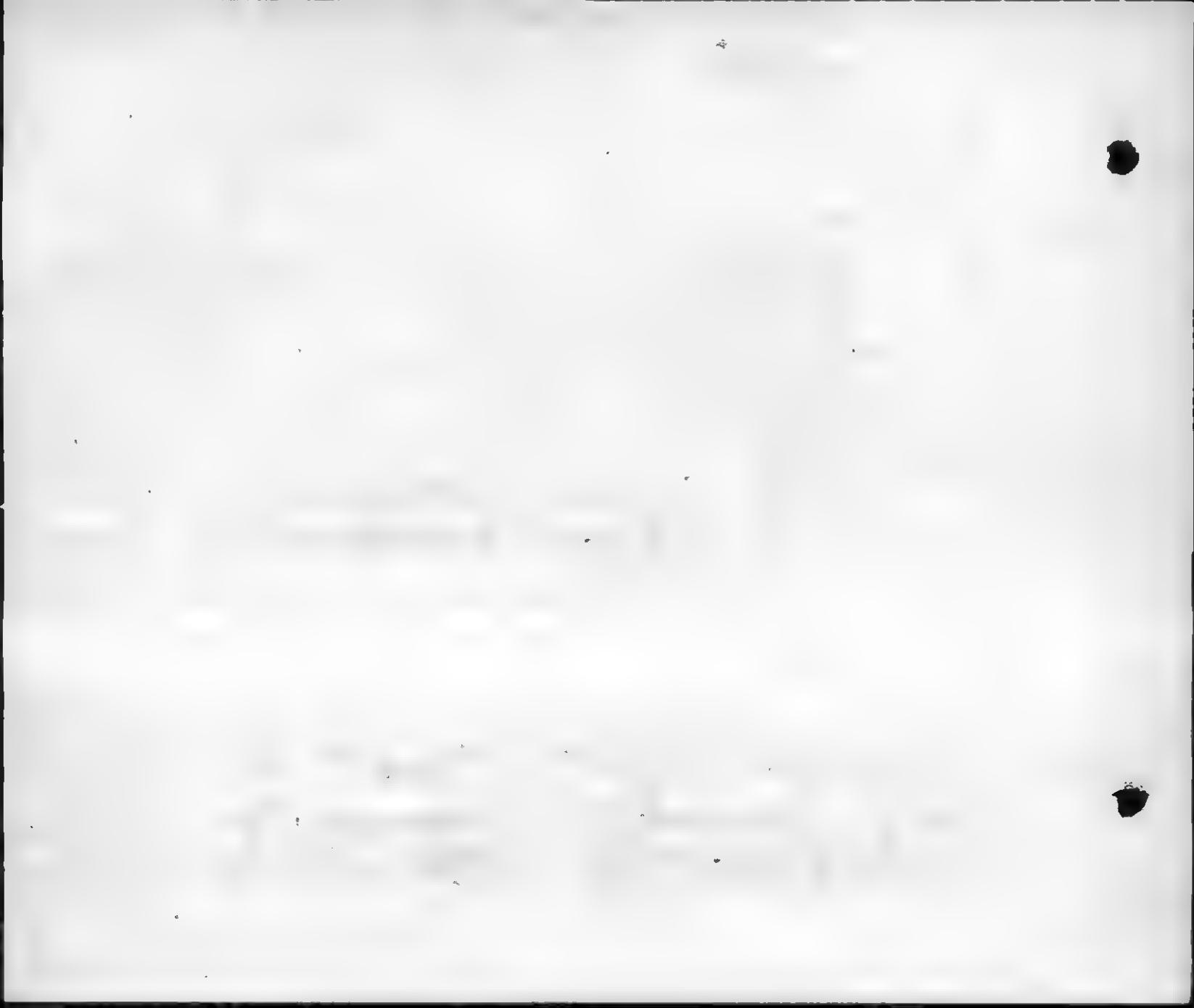
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

11792

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) Garlock Memorial Hospital		d. STREET ADDRESS 1325 Jefferson Blvd.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Joseph	Middle Earl	Last Harbaugh
4. DATE OF DEATH	Month Oct.	Day 4,	Year 1958
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 26, 1873
9. AGE (In years at death) 85 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farmer		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Chewsville, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME John Harbaugh		14. MOTHER'S MAIDEN NAME Martha Brown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Tel. no. or unknown) no		16. SOCIAL SECURITY NO - - -	
17. INFORMANT Mrs. Athene Brenner, Hagerstown, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 181.0 Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Carcinoma Bladder (c) DUE TO Arterio-venous Heart Disease		INTERVAL BETWEEN ONSET AND DEATH 2 yrs 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-4-1958, to 10-4-1958, that I last saw the deceased alive on 10-2-58, 1958, and that death occurred at 8:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE J. E. W. Sitter		ADDRESS (Street, city or town, state) Hagerstown, Md.	
PHYSICIAN'S NAME (Type) NEW F. T. T. G.		DATE SIGNED 17/6/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-6-58	
22c. NAME OF CEMETERY OR CEMETORY Smithsburg Cemetery		22d. LOCATION (City, town, or county) (State) Smithsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D. BY REGISTRAR DATE OCT 7 '58	
		24b. REGISTRAR'S SIGNATURE C. M. S. Krause	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11786 CERTIFICATE OF DEATH

11793

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE	
Washington MARYLAND		Penns. Franklin	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 1/2 yrs	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garlock Memorial Conv. home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Greencastle	
3. NAME OF DECEASED (Type or print)		d. STREET ADDRESS South Washington st	
First Anna J. Hawman		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX Female		4. DATE OF DEATH October 26 1958	
6. COLOR OR RACE White		5. SEX WIDOWED	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6. COLOR OR RACE WIDOWED	
8. DATE OF BIRTH 3/12/1869		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. AGE (In years last birthday) 89		8. DATE OF BIRTH 3/12/1869	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Housewife	
11. BIRTHPLACE (State or foreign country) Harrisburg, Penna		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John C. James		14. MOTHER'S MAIDEN NAME Mary B. Wolf	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO None	
17. INFORMANT Mrs. Clara Whitmore, Greencastle, Pa		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) Hemorrhaged arterio-sclerosis	
		INTERVAL BETWEEN ONSET AND DEATH 5 yr.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Doy, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March</u> , 1958, to <u>Oct 26</u> , 1958, that I last saw the deceased alive on <u>Oct. 20</u> , 1958, and that death occurred at <u>1:30 P.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) Greencastle, Franklin Co., Penna.	
ACTUAL SIGNATURE David R. Hess, M. D.		DATE SIGNED 1958	
PHYSICIAN'S NAME (Type) David R. Hess, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/29/1958	
22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Greencastle Franklin Co., Penna. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Arnold M. Glazerman		ADDRESS Greencastle, Pa.	
		24a. REC'D BY REGISTRAR DATE OCT 29 58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained in the hospital or attending physician's office. After this certificate has been signed by the attending physician and completely filled in by the medical director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

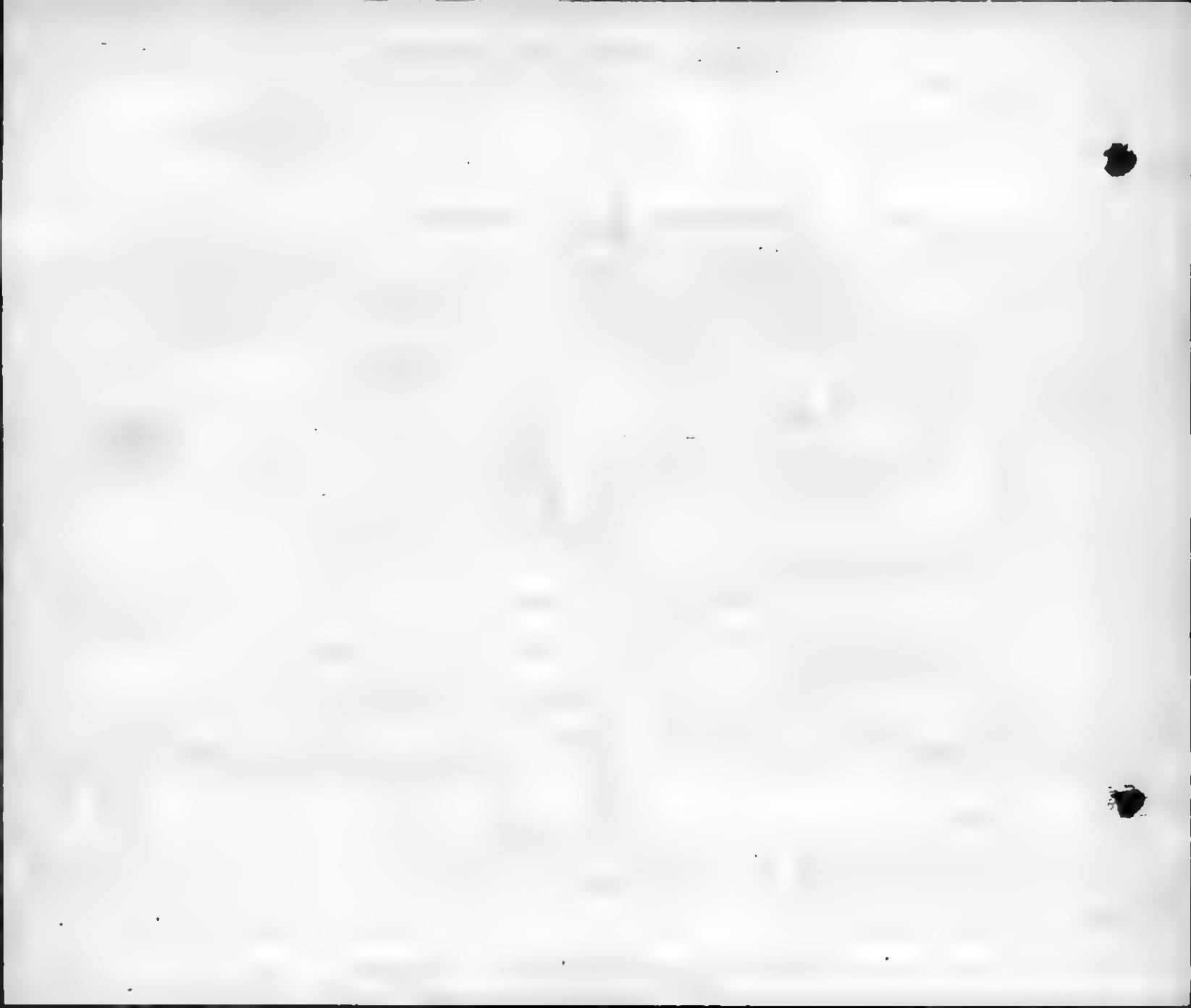
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11787 CERTIFICATE OF DEATH

11794
303

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 Weeks		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WASHINGTOW CO HOSP.		d. STREET ADDRESS Tilghmanton		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Day	Year	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH	9. AGE (In years lost, birthday) 68 yrs	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours	Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) CHAMBERSBURG, PA		12. CITIZEN OF WHAT COUNTRY U.S.			
13. FATHER'S NAME Brandt Vinson		14. MOTHER'S MAIDEN NAME May Heckman							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs Lucy Lambert Fairplay		Address 111			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 231X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Pulmonary Embolism mediastinal Tumors				INTERVAL BETWEEN ONSET AND DEATH 10 months			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown		(County)	(State)
21. I certify that I attended the deceased from <u>April</u> , 1958, to <u>OCT 20</u> , 1958, that I last saw the deceased alive on <u>10/20/58</u> , 1958, and that death occurred at <u>11:25 AM</u> , from the causes and on the date stated above. ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) JOHN D. TURCO						ADDRESS (Street, city or town, state) M.D. 302 N. POTOMAC ST HAGERSTOWN, MD		DATE SIGNED 10-20-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/22/58		22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Md. Co. Md.		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 22 '58		24b. REGISTRAR'S SIGNATURE John K. Coffman			



TO HOSPITAL OR ATTENDANT: This form requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11833 CERTIFICATE OF DEATH

11795

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg Md. RFD 2		c. LENGTH OF STAY IN 1b 70 yrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Sharpsburg Md. RFD 2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Antietam		d. STREET ADDRESS Antietam		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Harry	Middle David	Last Jamison	4. DATE OF DEATH Oct. 22	Month Oct.	Day 22	Year 1958
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 16 1888	9. AGE (In years last birthday) 70 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS Days 5	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance Dept.		10b. KIND OF BUSINESS OR INDUSTRY Fairchild Aircraft		11. BIRTHPLACE (State or foreign country) Antietam Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A.	
13. FATHER'S NAME Thomas Jamison		14. MOTHER'S MAIDEN NAME Annie Ebersole					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 220 10 3581		17. INFORMANT Address Antietam Anna Louise Jamison Sharpsburg Md. 2			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b)		Arteriosclerotic heart disease with coronary insufficiency DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 20 hours			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m.	Month 19	Day 19	Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) factory	20f. (City or town) Sharpsburg	(County) Md.
21. I certify that I attended the deceased from 10/21/58, 19, to 10/22/58, 19, that I last saw the deceased alive on 10/22/58, 19, and that death occurred at 2 P. M., from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Sharpsburg, Md.		DATE SIGNED Oct. 24, 58	
ACTUAL SIGNATURE Walter H. Shealy							
PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF Oct. 25-58	22c. NAME OF CEMETERY OR CREMATORIUM 116. View Cemetery	22d. LOCATION (City, town, or county) Sharpsburg Md.	(State)			
23. FUNERAL DIRECTOR'S SIGNATURE Alfred L. Williamsport Md.	ADDRESS	24a. REC'D BY REGISTRAR DATE OCT 27 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Tracy				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11796

11788

CERTIFICATE OF DEATH

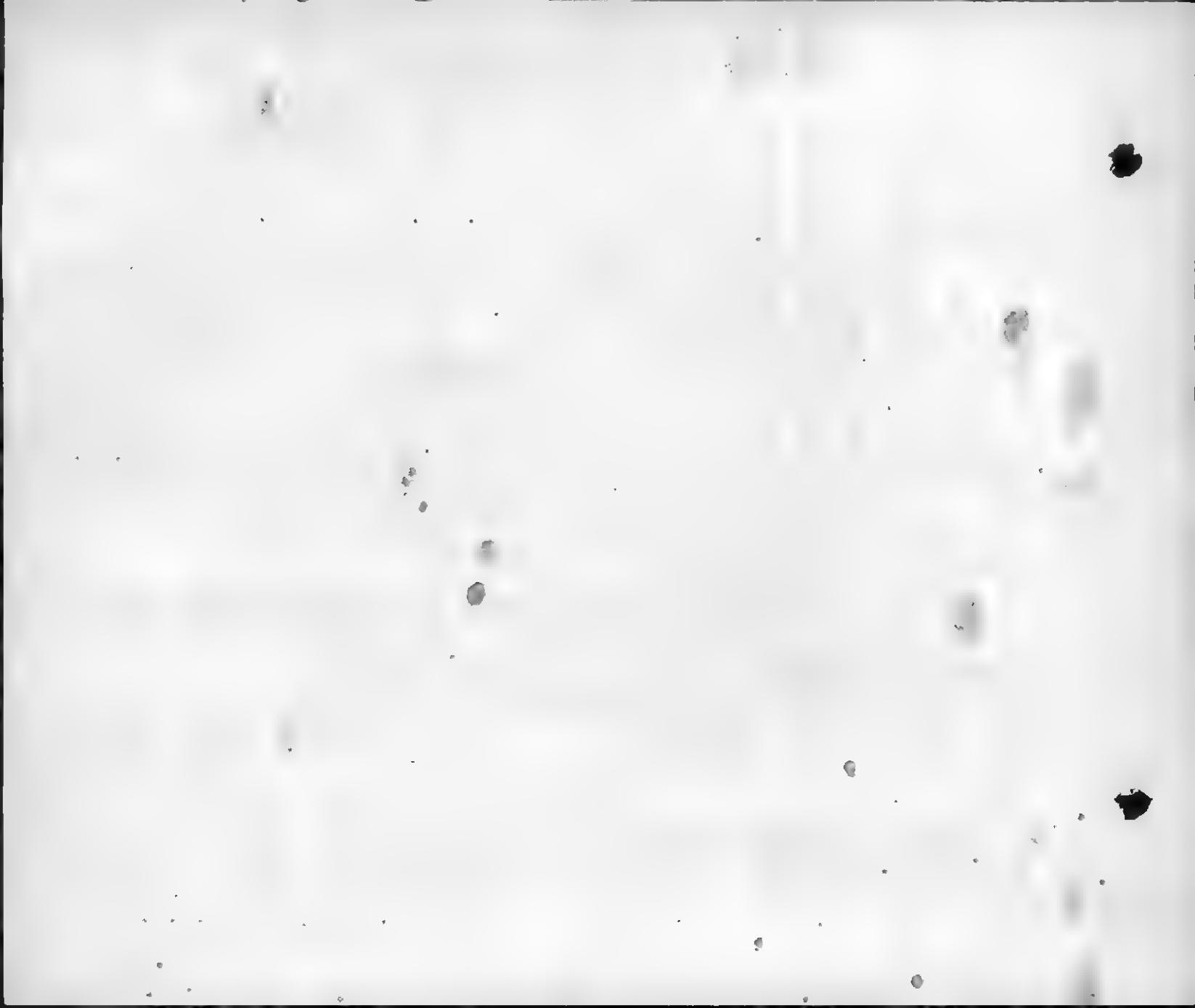
Reg. Dist. No

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 13 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 22 S. Mt. Valla Ave.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Convalescent Home				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) BENJAMIN		First, MIDDLE ROWE	LAST JONES	4. DATE OF DEATH October	Month 16,	Doy 1958	Year
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 7, 1873	9. AGE (In years last birthday) 84 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS Months 11 Days 9 Hours 0 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truant Officer		10b. KIND OF BUSINESS OR INDUSTRY School		11. BIRTHPLACE (State or foreign country) Bangor, Maine		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Rufus K. Jones		14. MOTHER'S MAIDEN NAME Sadie T. Gates				Address 22 Mont Valla Ave Hagerstown, Md.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-24-1584		17. INFORMANT Mrs. Ned R. Carlisle		INTERVAL BETWEEN ONSET AND DEATH 2 yrs.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. (b) DUE TO myocardial Failure (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Doy, Year Hour o m p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Hagerstown	(County) (State)
21. I certify that I attended the deceased from Jan. 1956, to Jan. 16, 1958, that I last saw the deceased alive on Jan. 16, 1958, and that death occurred at 8:15 P.M., from the causes and on the date stated above ACTUAL SIGNATURE F. F. Lusby				ADDRESS (Street, city or town, state) M.D. 2301 Potowmack Hagerstown, Md.		DATE SIGNED 17/6/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		22b. DATE THEREOF Oct. 18, 1958		22c. NAME OF CEMETERY OR CREMATORIAL J. William Lee's Sons Co.		22d. LOCATION (City, town, or county) Washington, D.C. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE, Albert H. Lee, Williamsport, Maryland		ADDRESS ADDRESS		24e. REC'D BY REGISTRAR DACT 20 58		24b. REGISTRAR'S SIGNATURE S. Kline	

1. HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page
may be retained by the hospital or attending physician.

2. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AT'S (4)
1SM 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11789

CERTIFICATE OF DEATH

11797

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Reisterstown Md.		c. LENGTH OF STAY IN 1b 10 Min.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hancock Maryland		d. STREET ADDRESS 	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS 		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Rosie	Middle Caroline	Last Lanehart	4. DATE OF DEATH Oct. 15 1958	Month Oct.	Day 15	Year 1958
5. SEX F.	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 17. 1900	9. AGE (In years lost birthday) 57 yrs	10. IF UNDER 1 YEAR 9 months	11. IF UNDER 24 HRS 28 days	12. HOURS 12. CITIZEN OF WHAT COUNTRY? U.S.A.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Geneva McBrown 3718 Coronado Rd.		11. BIRTHPLACE (State or foreign country) Cacapon W. VA			
13. FATHER'S NAME Sylvester Pittman		14. MOTHER'S MAIDEN NAME Ida M Ross					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No		16. SOCIAL SECURITY NO 213-10-5650		17. INFORMANT Geneva McBrown 3718 Coronado Rd.		Address Baltimore 7 Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442 x		DUE TO Acute myocarditis		INTERVAL BETWEEN ONSET AND DEATH >this			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b)		DUE TO cardiovascular					
(c)		PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Warfordsburg Fulton Penna.		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 15 1958 to Oct 15 1958 , that I last saw the deceased Oct 15 1958 , and that death occurred at 1230 AM , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) Hancock Md.		DATE SIGNED Oct 15 1958	
ACTUAL SIGNATURE L.M. Shaffer		M.D.					
PHYSICIAN'S NAME (Type) L.M. Shaffer		Hancock Maryland					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10.18.58		22c. NAME OF CEMETERY OR CREMATORIAL Presbyterian Cemetery		22d. LOCATION (City, town, or county) (State) Warfordsburg Fulton Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Howard J. Horne		ADDRESS Hancock Md.		24a. REC'D BY REGISTRAR Oct 21 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 20 Film 234 10-11-58 a.m.

11798

11790

CERTIFICATE OF DEATH

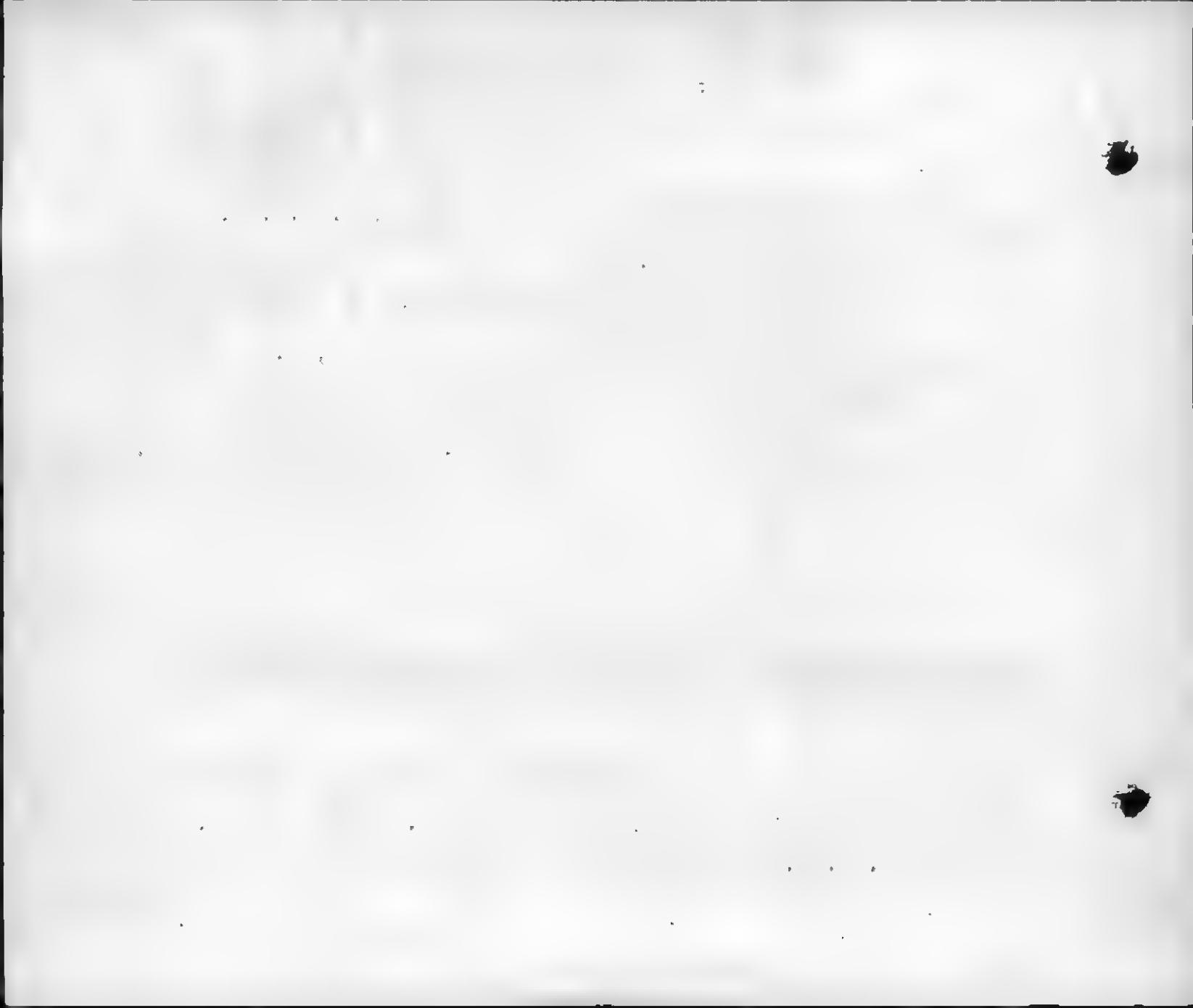
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 4 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL—Williamsport		d. STREET ADDRESS Hagerstown, Ed. R.F. D. #2	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Otho		First	Middle	Last	4. DATE OF DEATH Month October	Day 3	Year 1958
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 12, 1868	9. AGE (In years last birthday) 89 yrs	10. IF UNDER 1 YEAR: IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY Farming		11. BIRTHPLACE (State or foreign country) Near Fairplay, Md.		12. CITIZEN OF WHAT COUNTRY USA	
13. FATHER'S NAME Benjamin H. Lowry				14. MOTHER'S MAIDEN NAME Mary Catherine Hines			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None			
17. INFORMANT Beulah L. Lowry				18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 902.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO To fracture surgical neck of right humerus (c) DUE TO right humerus			
				INTERVAL BETWEEN ONSET AND DEATH Phenomenon of complication due to fracture surgical neck of right humerus 7 days			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Circumstances of accident Hagerstown			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Fell on back porch as was coming out doorway Struck right shoulder and upper arm on low step		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) back porch
						(County) (State) V. 25.	
21. I certify that I attended the deceased from <u>Aug 10</u> , 1958, to <u>Oct 3</u> , 1958, that I last saw the deceased alive on <u>Oct 3</u> , 1958, and that death occurred at <u>10:12</u> M, from the causes and on the date stated above.				ADDRESS (Street, city or town, state) 217 W. Washington St.			
ACTUAL SIGNATURE <u>Edward W. Ditto</u>				DATE SIGNED 10-4-58			
PHYSICIAN'S NAME (Type) Dr. E. W. Ditto III				Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 10/6/58		22b. DATE THEREOF 10/6/58		22c. NAME OF CEMETERY OR CREMATORIUM Mt. View Cemetery		22d. LOCATION (City, town, or county) (State) Sharpsburg, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert & Fred Williamsport, Md.</u>		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 6 '58		24b. REGISTRAR'S SIGNATURE <u>Charles S. Krause</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



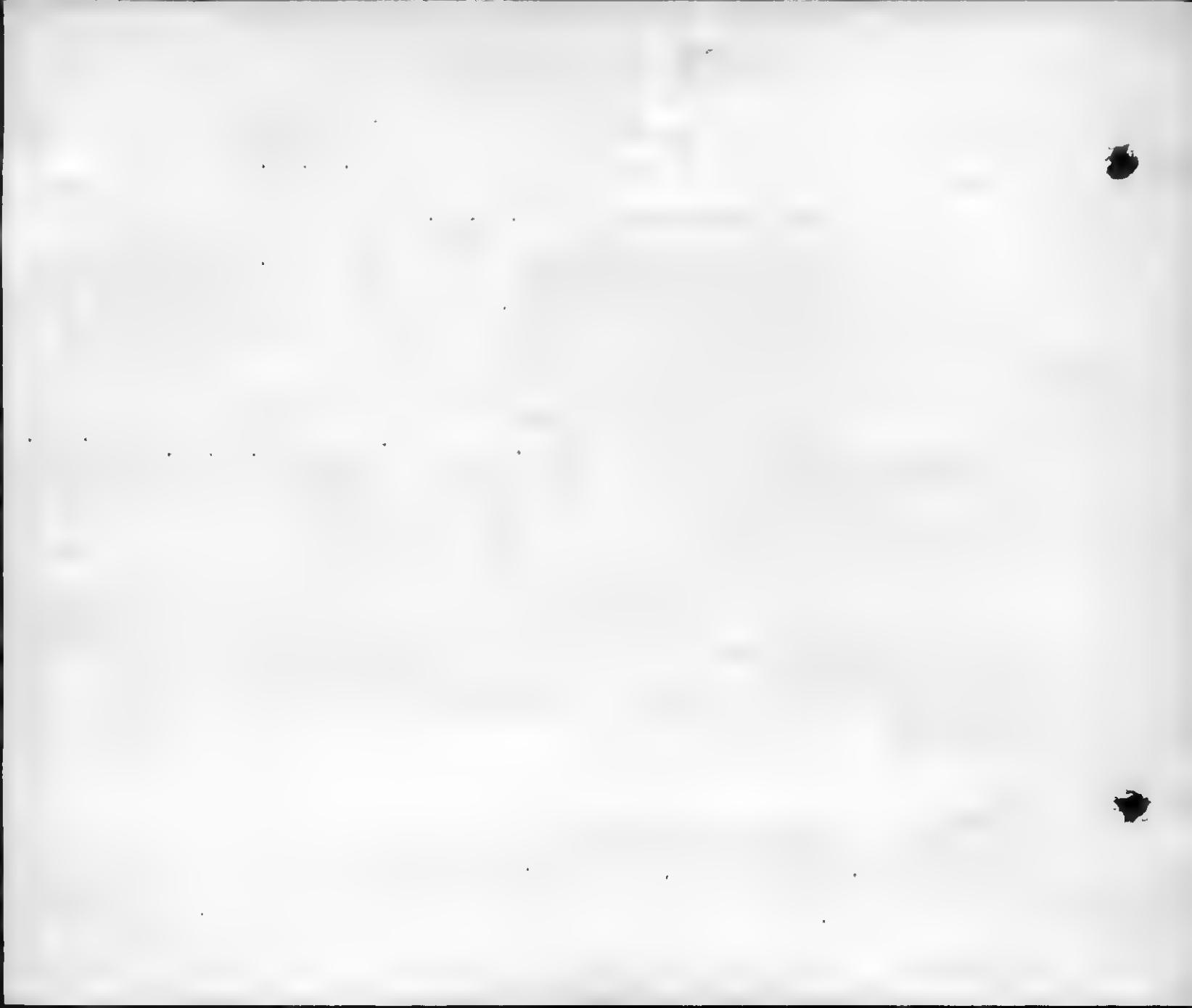
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11834 CERTIFICATE OF DEATH

Reg. Dist. No.

11799

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE West Va.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Willisport		b. COUNTY Berkeley	
c. LENGTH OF STAY IN 16 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Martinsburg R. F. D. #4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Williamsport Sanitarium		d. STREET ADDRESS R. F. D. #4 Martinsburg	
3. NAME OF DECEASED (Type or print) George Konstindine Magoutas		4. DATE OF DEATH Oct. 12	Month 1958 Doy Year
5. SEX Male		6. COLOR OR RACE White	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> Nov. 19 1889	
9. AGE (In years (last birthday) 68		10. IF UNDER 1 YEAR Months 10 Days 22 Hours 22 Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Confectioner		10b. KIND OF BUSINESS OR INDUSTRY Store	
11. BIRTHPLACE (State or foreign country) Turkey		12. CITIZEN OF WHAT COUNTRY U. S. A	
13. FATHER'S NAME Konstidine Magoutas		14. MOTHER'S MAIDEN NAME Katherine (Unknown)	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) 1-0		16. SOCIAL SECURITY NO. 233 50 7666	
17. INFORMANT Hrs. Rachel Magoutas R. F. D. #4		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) none	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Oct 1</u> , 1958 to <u>Oct 12</u> , 1958, that I last saw the deceased alive on <u>Oct 12</u> , 1958, and that death occurred at <u>599</u> M, from the causes and on the date stated above		ADDRESS (Street, city or town, state) M.D. DATE SIGNED 10-14-58	
ACTUAL SIGNATURE M. E. Byrkit			
PHYSICIAN'S NAME (Type) M. E. Byrkit, M.D.		28 W. Potomac Williamsport, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 15 1958 Riverview Cemetery	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) (State) Williamsport Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE M. E. Byrkit, Williamsport, Md.		24a. REC'D BY REGISTRAR OCT 15 '58	
ADDRESS		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11800
303

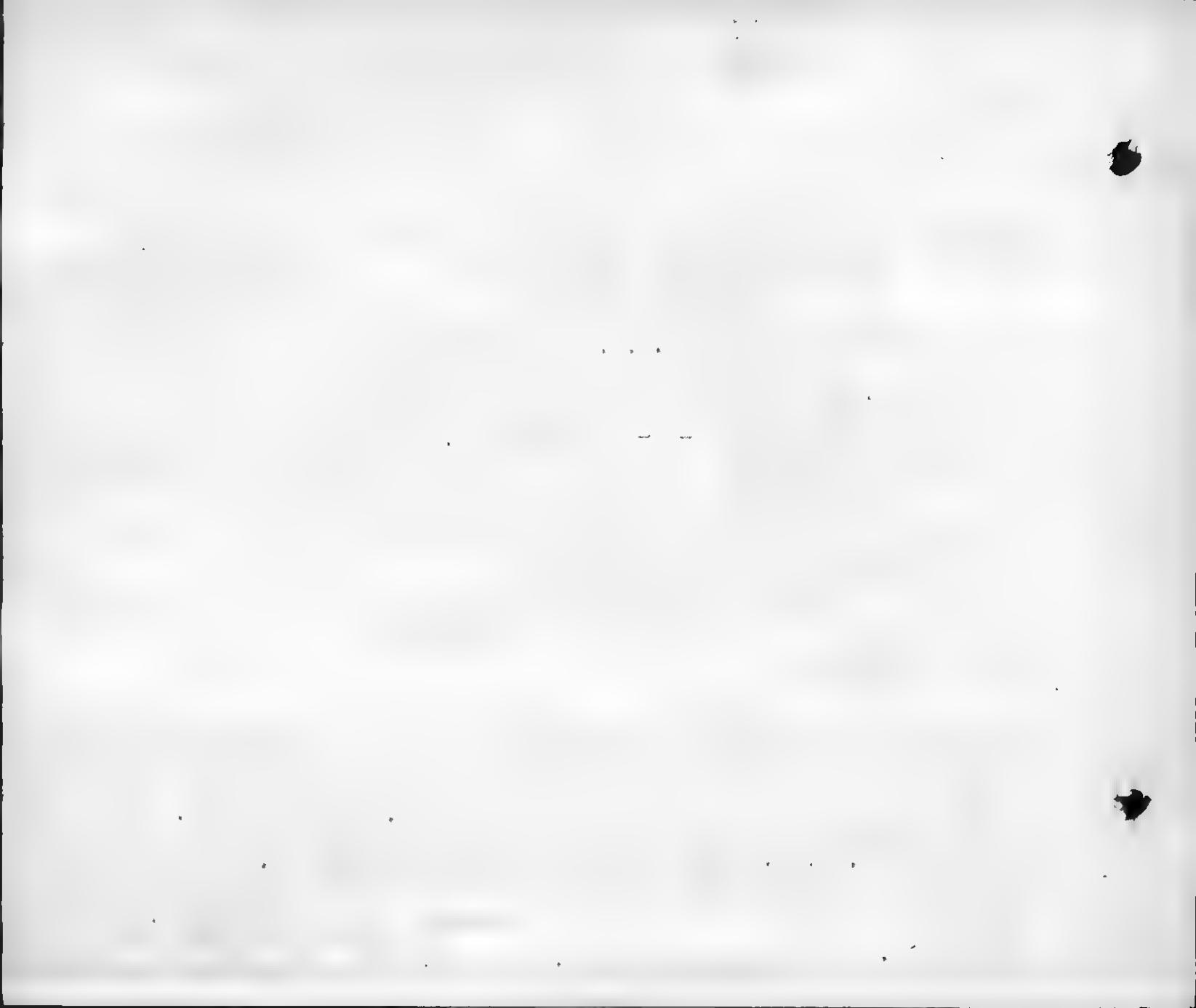
11791

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH Co. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) Co. STATE Maryland Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 3 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Hagerstown R # 4	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS Marshall St Extd		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) MARSHALL JEWELL MANSPEAKER		First	Middle	Last	4. DATE OF DEATH October 15 1958 19
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 1 1885	9. AGE (In years less birthday) 73 yrs. IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith Retired		10b. KIND OF BUSINESS OR INDUSTRY W. M. R. R.		11. BIRTHPLACE (State or foreign country) Bedford Bedford Co Pa	
13. FATHER'S NAME Wesley F. Manspeaker		14. MOTHER'S MAIDEN NAME Martha Jane West		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 705-10-4670		17. INFORMANT Blanche E. Manspeaker Hagerstown Md P 4	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>General arteriosclerosis & cerebral</u> INTERVAL BETWEEN DUE TO <u>4/21/50</u> ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <u>Thrombosis and arteriosclerotic</u> 1 yrs. (c) <u>Heart disease</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Benign Prostatic hypertrophy</u> (c) <u>Pneumonia</u> -					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jesus 24, 1958</u> to <u>OCT 15, 1958</u> that I last saw the deceased alive on <u>OCT 15, 1958</u> , and that death occurred at <u>12:12 M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 217 W. Washington St. DATE SIGNED					
ACTUAL SIGNATURE <u>Edward W. Ditto III</u> M.D.					
PHYSICIAN'S NAME (Type)		Dr. E. W. Ditto III Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/18/58		22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery	
22d. LOCATION (City, town, or county) Hagerstown Wash. Co Md					
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Cofinan Hagerstown Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 21 '58	
24b. REGISTRAR'S SIGNATURE Albert S. Nunn					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11792

CERTIFICATE OF DEATH

Reg. Dist. No.

11801

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		d. STREET ADDRESS 732 JEFFERSON		
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL				d. STREET ADDRESS 732 JEFFERSON		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) RICHARD		First	Middle	Last	4. DATE OF DEATH OCTOBLR	Month	Day	Year
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/21/1905		9. AGE (In years lost birthday) 53 yrs	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done if deceased not working, list even if retired) FOUNDRY SUPERVISOR		10b. KIND OF BUSINESS OR INDUSTRY BLAST CLEANING CO.		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME ELI M. MARTIN		14. MOTHER'S MAIDEN NAME LUCY WEAVER						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or unknown) NO		16. SOCIAL SECURITY NO 214-09-9096		17. INFORMANT MRS CATHERINE MARTIN		Address HAGERSTOWN MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 421.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Myocardial Failure aortic insufficiency				INTERVAL BETWEEN ONSET AND DEATH 1 week 10 yrs		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour e. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) HAGERSTOWN		(County) (State)
21. I certify that I attended the deceased from <u>Apr</u> , 19 <u>46</u> , to <u>30 Sept</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>30 Oct</u> , 19 <u>57</u> , and that death occurred at <u>2:55</u> M. from the causes and on the date stated above. ACTUAL SIGNATURE F. F. Lusby PHYSICIAN'S NAME (Type) F. F. Lusby				M.D. 230 N Potomac Hagerstown		ADDRESS (Street, city or town, state) HAGERSTOWN, MD.		DATE SIGNED 3/09/58
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 11/2/58		22c. NAME OF CEMETERY OR CREMATORIAL ROSE HILL, CEM.		22d. LOCATION (City, town, or county) HAGERSTOWN, MD. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Horment, Hagerstown, Md.		ADDRESS		24a. REC'D BY REGISTRAR NOV 3 '58		24b. REGISTRAR'S SIGNATURE Carroll S. Krause		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filled with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

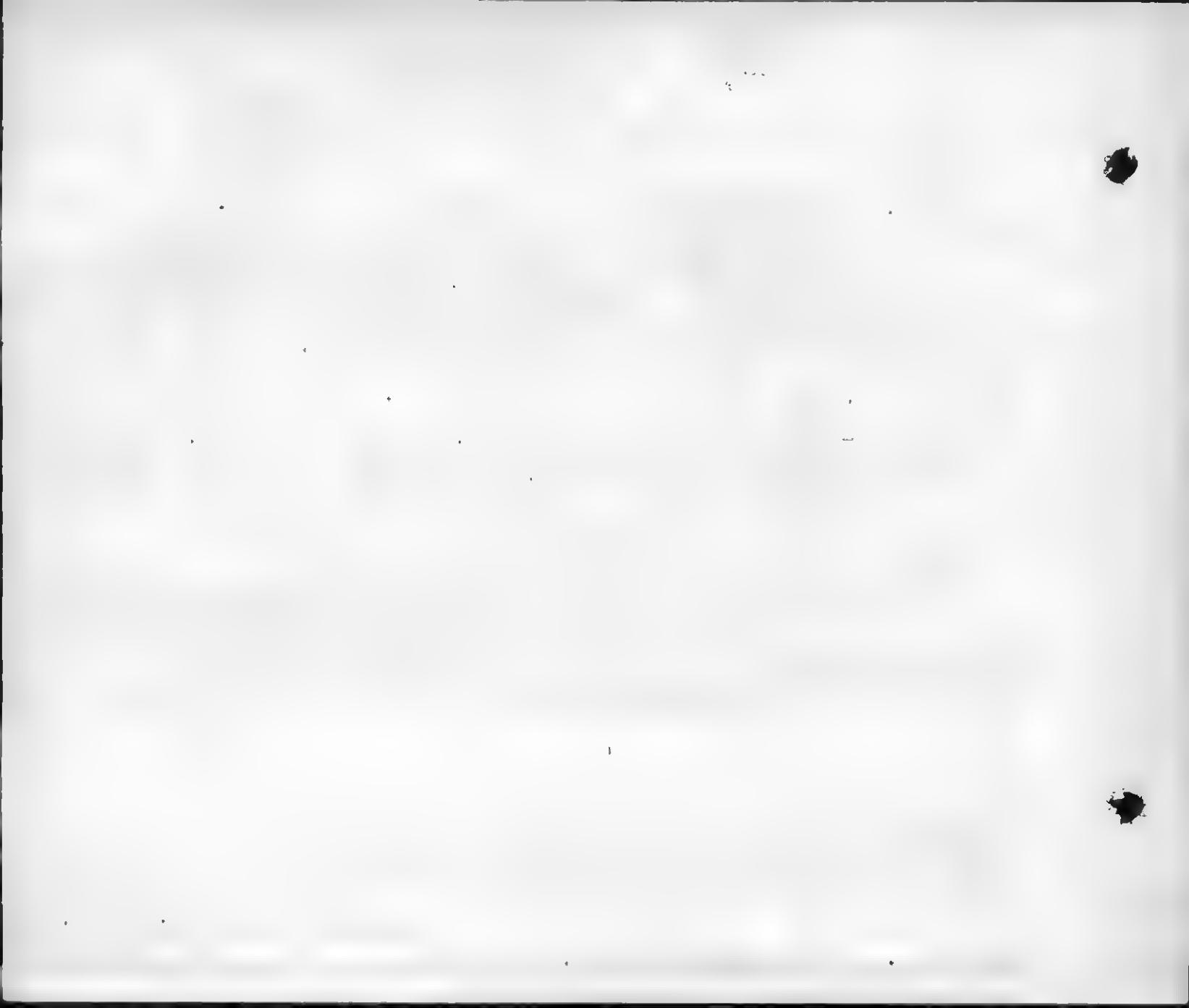
11793

CERTIFICATE OF DEATH

11802
002

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 2 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown R # 6		d. STREET ADDRESS Paramount	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION sh. County Hospital						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First JODY	Middle LORRAINE	Last MAY	4. DATE OF DEATH	Month October	Day 3	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH September 30 1958	9. AGE (In years at birthday) 01 yrs.	10. IF UNDER 1 YEAR Months 2	11. IF UNDER 24 HRS. Days 3	12. IF UNDER 24 HRS. Hours 45 Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY Infant		11. BIRTHPLACE (State or foreign country) Hagerstown Wash. Co Md		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Lloyd A. May				14. MOTHER'S MAIDEN NAME Betty L. Hause			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Lloyd A. May Hagerstown Md. R # 6		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause (b). DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (b) DUE TO (d) (e) (f)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/30 , 1958, to 10/2 , 1958, that I last saw the deceased alive on 10/2 , 1958, and that death occurred at 3:15 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 101 King St. Hagerstown DATE SIGNED 10/3/58							
ACTUAL SIGNATURE <i>Ruth A. Young</i>		PHYSICIAN'S NAME (Type)					
22a. BURIAL, CREMAT. ON, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/3/58		22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash. Co Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Cofman Hagerstown Md.		ADDRESS 2081-2644		24a. REG'D BY REGISTRAR 601-658		24b. REGISTRAR'S SIGNATURE and S. Meale	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11794

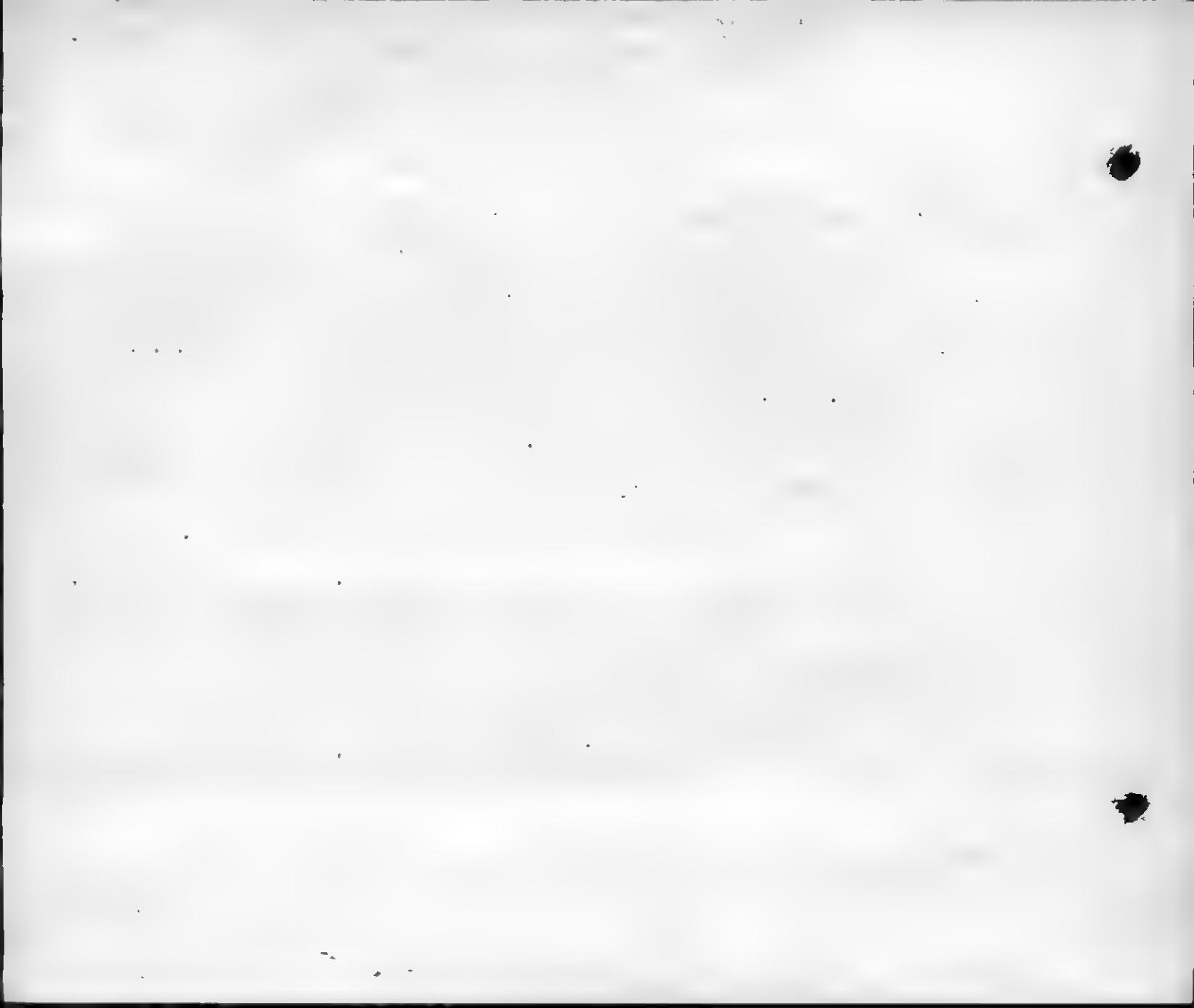
CERTIFICATE OF DEATH

11803
302

Reg. Dist. No.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1 PLACE OF DEATH o COUNTY Washington		2 USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) o. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 1 week	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
3 NAME OF DECEASED (Type or print) WARREN		First LEON	Middle MC CLURE, SR.
4. DATE OF DEATH October 6 1958		Month Oct	Day 6
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH December 22, 1897
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Material Inspector		10b. KIND OF BUSINESS OR INDUSTRY Dyeing plant	11. BIRTHPLACE (State or foreign country) New York State
13. FATHER'S NAME James O. Mc Clure		14. MOTHER'S MAIDEN NAME unknown	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO 1920-1922	17. INFORMANT Mrs. Carrie Mc Clure
			Address Hagerstown, Maryland
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4-0-1 Fulmonary Embolism			
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Coronary Occlusion Myocardial Infarct. days			
DUE TO (c) Artherosclerosis Generalized. years.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) not hing			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) none	
20c. TIME OF INJURY Month, Doy, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Hagerstown		(County) (State) Hagerstown, Maryland	
21. I certify that I attended the deceased from Sept 28, 1958, to Oct 6, 1958, that I last saw the deceased alive on Oct 5, 1958, and that death occurred at 12:30, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Louis S. Graff</i>	ADDRESS (Street, city or town, state) 119 E. Antietam Hagerstown, MD		DATE SIGNED 10/6/58
PHYSICIAN'S NAME (Type) Louis S. Graff			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/8/1958	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery	22d. LOCATION (City, town, or county) Hagerstown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Ouizer Funeral Home R. Franklin Suter	ADDRESS Hagerstown, Maryland	24a. REC'D BY REGISTRAR DATE OCT 9 '58	24b. REGISTRAR'S SIGNATURE Cather S. Kraus



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director
 page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11795 CERTIFICATE OF DEATH

Reg. Dist. No. 11804

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md. b. COUNTY Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 116 Irvin Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Lost 4. DATE OF DEATH Anna Margaret Elizabeth Middlekauff Oct. 9, 1958		Month Day Year	
5. SEX female 6. COLOR OR RACE white 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 30, 1884 9. AGE (In years last birthday) yrs. 73	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) house wife		10b. KIND OF BUSINESS OR INDUSTRY 11. BIRTHPLACE (State or foreign country) Hagerstown, Md.	
13. FATHER'S NAME Louis Heist		14. MOTHER'S MAIDEN NAME Jane Waggoner	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) no		16. SOCIAL SECURITY NO. 17. INFORMANT 212-24-5930 Hugh E. Middlekauff, Hagerstown, Md. Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] Part I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Tracheo-Bronchial Obstruction. INTERVAL BETWEEN 231X DUE TO ONSET AND DEATH 4 minutes. Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Massive Post nasal hemorrhage 4 minutes. DUE TO (c) Tumor post nasal space eroding artery. Unknown. Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9.10.48, 19, to 10.9.58, 19, that I last saw the deceased alive on 10.9.58, 19, and that death occurred at 8.00 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>Earl Young M.D.</i> ADDRESS (Street, city or town, state) DATE SIGNED 148 N. Potomac St., 10.10.58 PHYSICIAN'S NAME (Type) S. Earl Young M.D. Hagerstown, Md.			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10-14-58 22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery 22d. LOCATION (City, town, or county) (State) Hagerstown, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Scott F. Minnich & Son, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE OCT 14 '58 24b. REGISTRAR'S SIGNATURE C. Young ? Kraus	

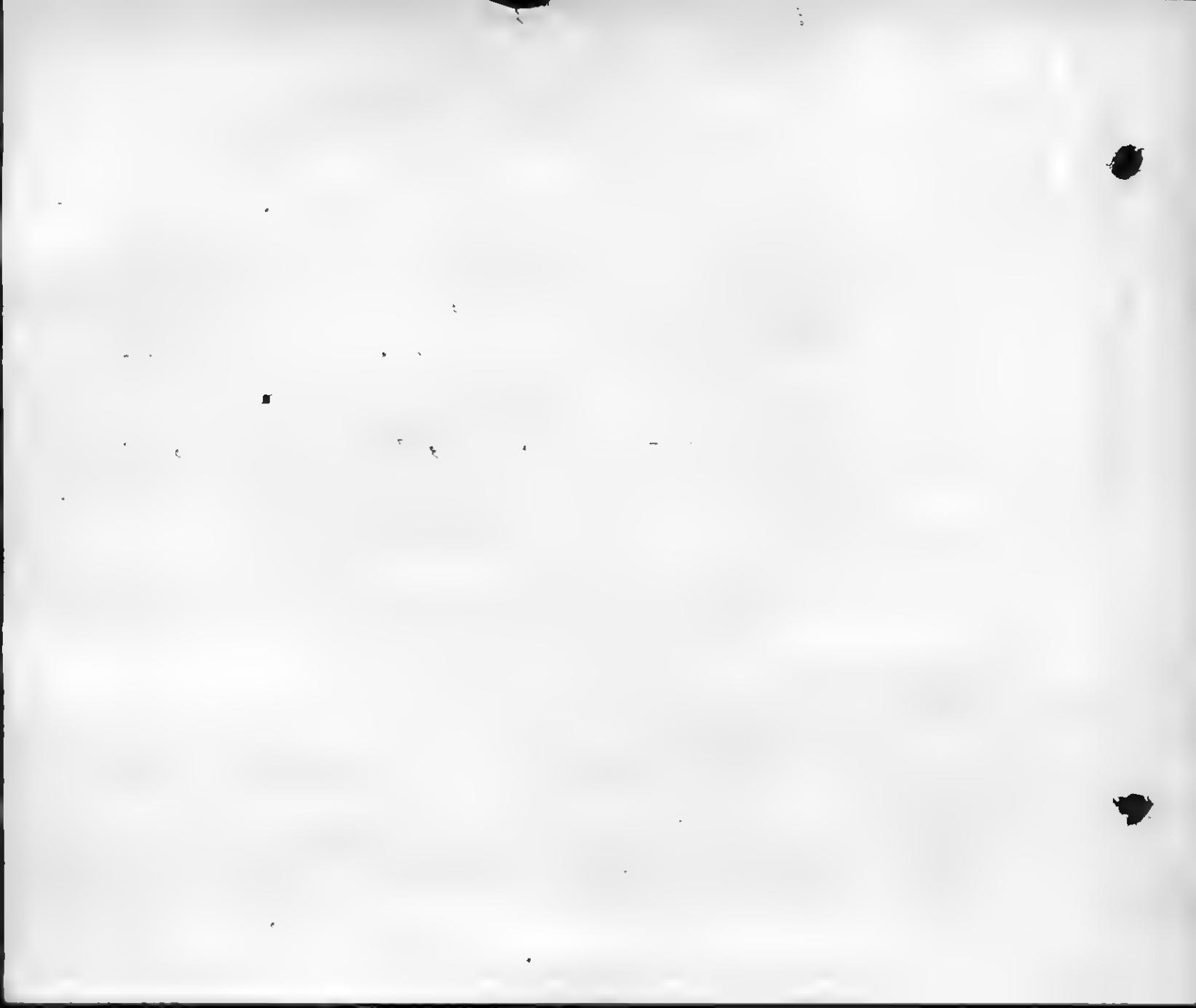
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11796

CERTIFICATE OF DEATH

11805
Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 day	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
f. STREET ADDRESS 158 South Prospect St.		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ROBERT	Middle EDWARD	Last HARRIS
4. DATE OF DEATH October 22, 1958	Month	Day	Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 14, 1884
		DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) 74 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Furniture Store	
11. BIRTHPLACE (State or foreign country) Keyser, W. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Charles Miers		14. MOTHER'S MAIDEN NAME Mary Willie Anderson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. 214-09-2910A 17. INFORMANT Mrs. Mary E. Miers, Hagerstown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute aspiration pneumonia DUE TO 517X		INTERVAL BETWEEN ONSET AND DEATH 30 min.	
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) Internal abdominal hernia DUE TO		1-2 days	
(c) Abdominal adhesions		1/2 day	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized arteriosclerosis		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	
20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20e. (City or town) White at work <input type="checkbox"/> Not white at work <input type="checkbox"/>		(County) (State)	
21. I certify that I attended the deceased from 1/22, 1958, to 10/22, 1958, that I last saw the deceased alive on 10/22, 1958, and that death occurred at 12:30 P.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE John C. Stauffer	M.D.	145 S. Prospect St.	10/23/58
PHYSICIAN'S NAME (Type) John C. Stauffer, M.D.	Hagerstown, Maryland		
22a. BURIAL CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/25/1958	22c. NAME OF CEMETERY OR CREMATORIAL Rest Haven Cemetery	22d. LOCATION (City, town, or county) Hagerstown, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home Hagerstown, Md.	ADDRESS R. Stauffer	24a. REC'D BY REGISTRAR DATE OCT 27 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus



MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 7 File 10-14-58 et
11835

CERTIFICATE OF DEATH

Reg. Dist. No. 11806

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) b. STATE MARYLAND		b. COUNTY WASHINGTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SAN MAR		c. LENGTH OF STAY IN 1b 2 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BOONSBORO					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION FAHRNEY KEEDY MEMORIAL HOME				d. STREET ADDRESS LAKIN AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First CORA	Middle E.	Last MILLER	4. DATE OF DEATH	OCTOBER 3 1958	Month Oct	Day 19	Year 1958	
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED WIDOWED <input type="checkbox"/>	NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 8 1868	9. AGE (In years last birthday) 90 yrs.	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	Hours 0	Min 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) MT. CARMEL WASH.CO.MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME JOSHUA MILLER		14. MOTHER'S MAIDEN NAME AMANDA SHIFLER							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO NONE		17. INFORMANT MRS. VERNON HARPT BOONSBORO MD.		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 5 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	Year	20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>May 2, 1958</u> to <u>Oct 3, 1958</u> that I last saw the deceased alive on <u>October 3, 1958</u> , and that death occurred at <u>Boonsboro</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>G. William</u> M.D. <u>Boonsboro</u> <u>MD</u> DATE SIGNED <u>10/4/58</u>									
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 6 1958		22c. NAME OF CEMETERY OR CREMATORIUM BOONSBORO CEMETERY		22d. LOCATION (City, town, or county) BOONSBORO WASH.CO.MD.			
23. FUNERAL DIRECTOR'S SIGNATURE <u>John D. Bark</u>		ADDRESS <u>Boonsboro Md.</u>		24a. REC'D BY REGISTRAR DATE OCT 9 '58		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11836 CERTIFICATE OF DEATH

11807

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willia...sport Md.		c. LENGTH OF STAY IN 1b 7 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 209 South Vermont Street		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willia...sport Md.	
3. NAME OF WILLIE (Type or print) James		First Middle Curl	4. DATE OF DEATH Oct. 27 1958 Month Day Year
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1 1893 9. AGE (In years last birthday) 65 yrs 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Labor
10b. KIND OF BUSINESS OR INDUSTRY Orchards		11. BIRTHPLACE (State or Foreign country) Berkeley Springs W. Va	
12. CITIZEN OF WHAT COUNTRY U. S. A		13. FATHER'S NAME Unknown	
14. MOTHER'S MAIDEN NAME Minnie Jackson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) No	
16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Frances Miller	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Address 209 S. Vermont St. Williamsport, Md. INTERVAL BETWEEN ONSET AND DEATH /July	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>10/27/58</u> to <u>10/27/58</u> , that I last saw the deceased alive on <u>10/27/58</u> , and that death occurred at <u>470 S. Vermont St.</u> , from the causes and on the date stated above ADDRESS (Street, city or town, state) M.D. <u>Ralph J. Young</u> <u>Williamsport, Md.</u> DATE SIGNED <u>10/27/58</u>			
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 30-58	22c. NAME OF CEMETERY OR CREMATORIUM Bethel Church Cemetery Near Berkeley Springs W. Va
23. FUNERAL DIRECTOR'S SIGNATURE <u>Albert J. Smith Williamsport, Md.</u>		24a. REC'D. BY REGISTRAR OCT 30 '58	24b. REGISTRAR'S SIGNATURE <u>Albert J. Smith</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours of death.

VS A15 (4)
1SM 10/52



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4
 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
 page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
 the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11797

CERTIFICATE OF DEATH

11808

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		b. COUNTY WASHINGTON	
c. LENGTH OF STAY IN 1b RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WESTERN MARYLAND STATE HOSPITAL		d. STREET ADDRESS 31 W. BETHEL	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) MARY		First	Middle
4. DATE OF DEATH OCTOBER 14 1958		Last	Month Day Year
5. SEX FEMALE		6. COLOR OR RACE COLORED	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 89 7 3		9. AGE (in years last birthday) 89 7 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) White Post, Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME UNKNOWN		14. MOTHER'S MAIDEN NAME UNKNOWN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]			
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CONFLUENT LOBULAR PNEUMONIA BILATERAL INTERVAL BETWEEN ONSET AND DEATH 1 WEEK			
420.0 DUE TO			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last (b) PULMONARY EMBOLI 1 WEEK			
DUE TO (c) ARTERIOSCLEROTIC HEART DISEASE UNKNOWN			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
4. BENIGN NEPHROSCLEROSIS 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from SEPTEMBER 26 1958 to OCT. 14 1958 , that I last saw the deceased alive on OCT. 14 1958 , and that death occurred at 9:37 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>George Bercu</i>		ADDRESS (Street, city or town, state) M.D. 1500 PENNSYLVANIA AVE. DATE SIGNED 10/15/58.	
PHYSICIAN'S NAME (Type) DR. GEORGE BERCU.		HAGERSTOWN, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/18/58	
22c. NAME OF CEMETERY OR CREMATORIUM Rivertown Cemetery		22d. LOCATION (City, town, or county) Hagerstown, Maryland (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John K. Watson of Hagerstown, Md.</i>		ADDRESS	
24e. REC'D BY REGISTRAR REG'D 11 7 58		24f. REGISTRAR'S SIGNATURE Arthur S. ...	



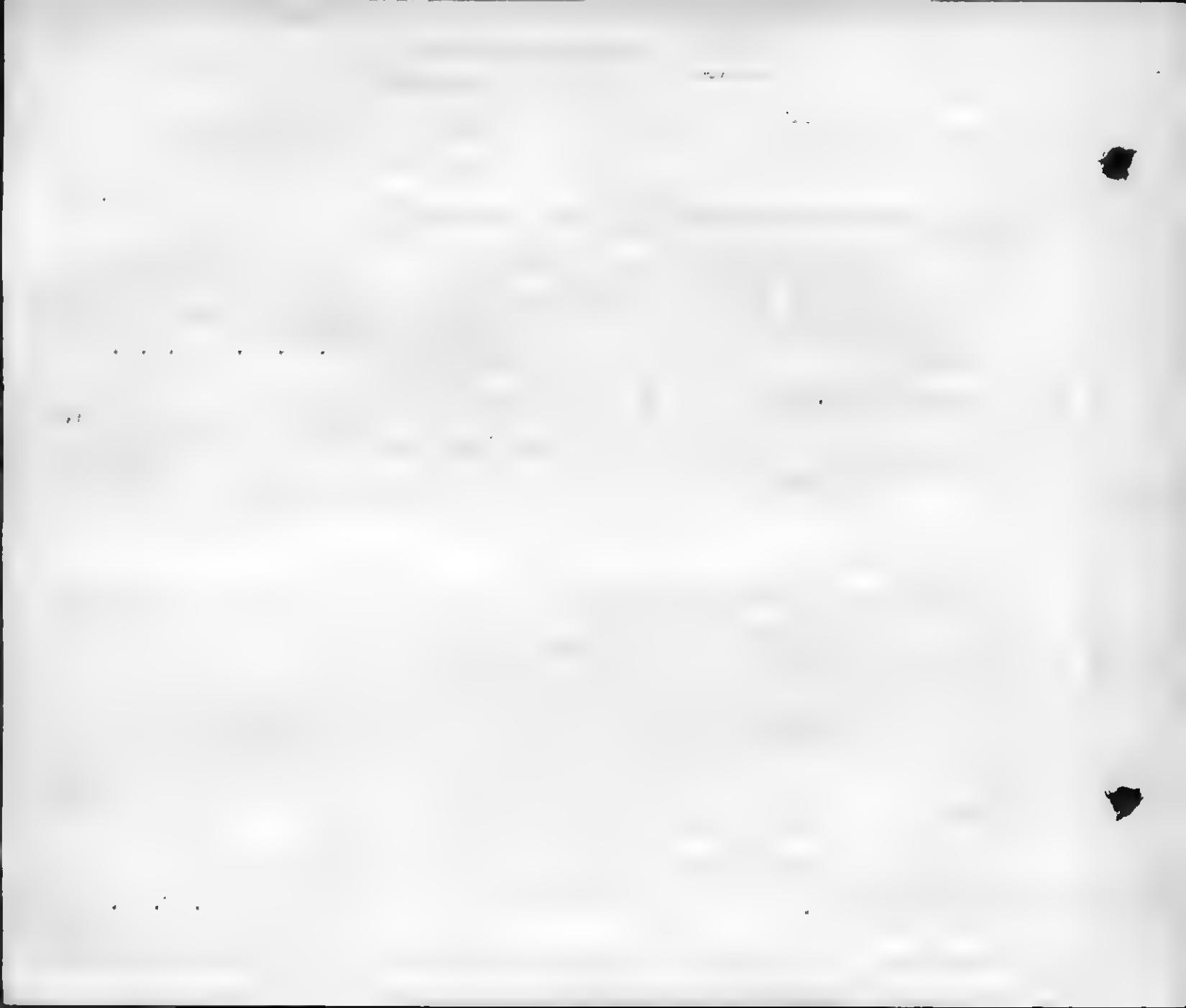
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11837 CERTIFICATE OF DEATH

11809

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R. L. L. R. S. B. Y.		b. COUNTY WASHINGTON	
c. LENGTH OF STAY IN lb 60 YEARS		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) R. R. R. S. B. Y.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Hospital		d. STREET ADDRESS MAIN STREET	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) LIZZIE		4. DATE OF DEATH OCTOBER 17 1958 19	
5. SEX FEMALE		6. COLOR OR RACE WHITE	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH DECEMBER 11 18786	
WIDOWED <input checked="" type="checkbox"/>		9. AGE (In years lost birthday) 82 yrs.	
DIVORCED <input type="checkbox"/>		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
10c. BIRTHPLACE (State or foreign country) BENEVOLA WASH. CO. MD.		11. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE W. STINE		14. MOTHER'S MAIDEN NAME ELIZA HOOVER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 218-38-2193	
17. INFORMANT HUBERT MULLENDORE		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Arteriosclerotic Heart Disease with myocardial failure</i>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1958 to Oct 1958 , that I last saw the deceased alive on 15 Oct 1958 , and that death occurred at 11-10 P.M. from the causes and on the date stated above. ACTUAL SIGNATURE FF Lusby PHYSICIAN'S NAME (Type) FF Lusby		ADDRESS (Street, city or town, state) 230 N. Potowmack Hagerstown DATE SIGNED 18 Oct 58	
22a. BURIAL, CREMATION, REMOVAL (Specify) ENTOMBMENT		22b. DATE THEREOF OCT. 20 1958	
22c. NAME OF CEMETERY OR CREMATORIUM BOONSBORO MAUSOLEUM		22d. LOCATION (City, town or county) (State) BOONSBORO WASH. CO. MD.	
23. FUNERAL DIRECTOR'S SIGNATURE John D. Bost		24a. ADDRESS Boonsboro Md	
24b. REC'D BY REGISTRAR DATE OCT 22 '58		24c. REGISTRAR'S SIGNATURE Clara S. Kline	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11798

CERTIFICATE OF DEATH

11810

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE							
Washington MARYLAND		Maryland Washington							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN lb 28 yrs.							
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 921 St.Clair St.		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown							
3. NAME OF DECEASED (Type or print)		First JOHN	Middle HENRY						
4. DATE OF DEATH		Month Oct.	Day 7						
5. SEX		5. COLOR OR RACE	6. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	7. WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 71 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days Hours Min.	
Male		White			Jan. 9, 1887				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11 BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?			
Retired		Penns.R.R.		Franklin County, Pa.		USA			
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME							
William Mumment		Annie Myers							
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
No		214-09-4652		Mrs. J. H. Mumment		921 St.Clair St. Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Severe Arterio Sclerotic Heart disease					2 yrs.		
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost.		with myocardial failure							
DUE TO (b)									
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While Not while of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Aug 15, 1956, to Oct 8, 1958, that I last saw the deceased alive on 7 Oct 1958, and that death occurred at 11:30 P.M., from the causes and on the date stated above							ADDRESS (Street, city or town, state)		
ACTUAL SIGNATURE F. F. Lusby		M. D. 230 N Potomac Hagerstown Md					DATE SIGNED 8 Oct 58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/10/58		22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc.		ADDRESS 1601 Penna. Ave. Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE OCT 10 '58		24b. REGISTRAR'S SIGNATURE Clymer S. Trahan			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11838 CERTIFICATE OF DEATH

11811

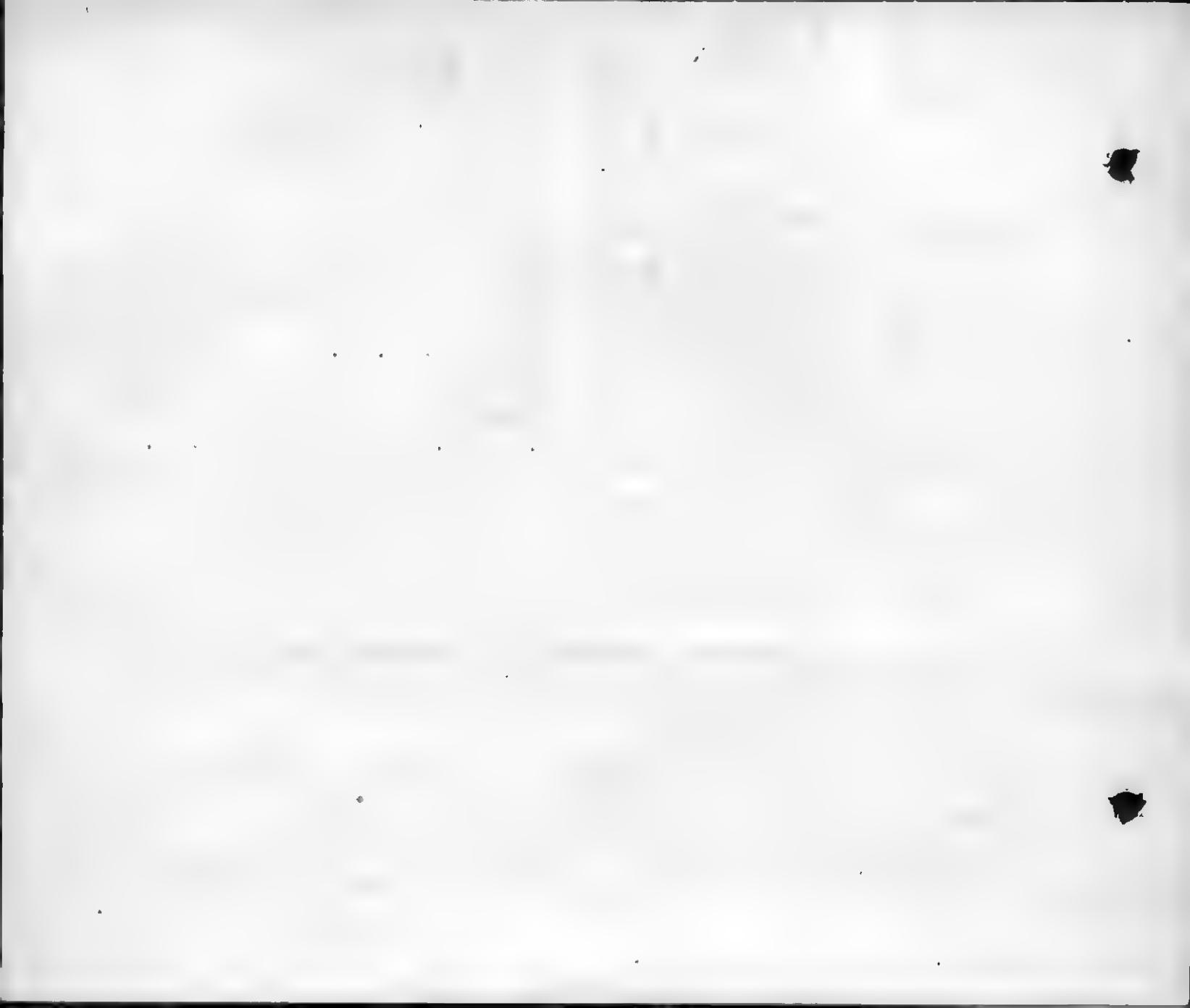
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Boonsboro Rural		c. LENGTH OF STAY IN 1b 5 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Fahrney Keedy Memorial Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown rural	
f. STREET ADDRESS		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Emma	Middle Rebecca	Last Mundey
4. DATE OF DEATH	Month 10	Day 26	Year 1958
5. SEX female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH 6-24-1869
9. AGE (In years last birthday) 89 yrs	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
13. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) homework	14. KIND OF BUSINESS OR INDUSTRY home	15. BIRTHPLACE (State or foreign country) Wash. Co. Md.	16. CITIZEN OF WHAT COUNTRY U.S.A.
17. FATHER'S NAME John Mundey	18. MOTHER'S MAIDEN NAME Ann E Gassman	Address Hagerstown, Md. R710	
19. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no	20. SOCIAL SECURITY NO. none	21. INFORMANT Mrs. John B. Huyett	22. IF INTERVAL ONSET AND DEATH 10 yrs
23. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		24. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		26. WAS ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
27. TIME OF INJURY Hour o. m. p. m.		28. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
29. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		30. (City or town) (County) (State)	
31. I certify that I attended the deceased from <u>June 24, 1958</u> to <u>6-24-58</u> that I last saw the deceased alive on <u>6-24-58</u> and that death occurred at <u>6-24-58</u> M. from the causes and on the date stated above ACTUAL SIGNATURE <u>G. W. Heelan</u>		32. ADDRESS (Street, city or town, state) <u>Boonsboro, Md.</u> DATE SIGNED <u>10/28/58</u>	
33. BURIAL, CREMATION, REMOVAL (Specify) burial		34. DATE THEREOF 10-29-58	
35. NAME OF CEMETERY OR CREMATORIAL Rose Hill		36. LOCATION (City, town, or county) (State) Hagerstown Md.	
37. FUNERAL DIRECTOR'S SIGNATURE Fred W. Kraiss Hagerstown, Md.		38. REC'D BY REGISTRAR DATE OCT 30 '58	
39. REGISTRAR'S SIGNATURE Arthur S. Kraiss			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11812

11839 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Washington</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Boonsboro Rural</i>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington</i>	
c. LENGTH OF STAY IN 1b <i>10 yrs</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Boonsboro Rural</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Fulmer - Keedy. Mem. Home</i>		d. STREET ADDRESS <i>1</i>	
3. NAME OF DECEASED (Type or print) <i>Ada Kate Murray</i>		4. DATE OF DEATH <i>Oct 14</i>	Month Year <i>1958</i>
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Oct 4 1862</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Huff</i>	
11. BIRTHPLACE (State or foreign country) <i>Ind</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Mordecai Boring</i>		14. MOTHER'S MAIDEN NAME <i>Vera Barnes</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>212-12-5894</i>	
17. INFORMANT (Name, address, or date of service) <i>Newton Boring - Hampstead Md</i>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>450.0</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first. (b) DUE TO (c)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <i>1 yrs</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <i>19</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Newton Boring - Hampstead Md</i>		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>Oct 13</i> , 1958, to <i>Oct 14</i> , 1958, that I last saw the deceased alive on <i>Oct 13</i> , 1958, and that death occurred at <i>11:05 AM</i> , from the causes and on the date stated above. ACTUAL SIGNATURE <i>G. Wilhelm M.D.</i>		ADDRESS (Street, city or town, state) <i>130 Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Oct 16/58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Hampstead</i>		22d. LOCATION (City, town or county) <i>Carroll Co Ind</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Edie S. Kipson, Hampstead Md</i>		24a. ADDRESS <i>130 Maryland</i>	
24b. REC'D BY REGISTRAR DATE <i>OCT 17 '58</i>		24c. REGISTRAR'S SIGNATURE <i>C. L. S. Kraus</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11799 CERTIFICATE OF DEATH

11813

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) o. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Hagerstown		c. LENGTH OF STAY IN 1b 3 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington Co. Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Fairplay	
3. NAME OF DECEASED (Type or print) Etta		d. STREET ADDRESS Fairplay R.D.#1	
First Etta		Middle Page	Loss Near
4. DATE OF DEATH 10	Month 10	Day 20	Year 1958
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 21 1883
9. AGE (In years lost birthday) 74 yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Domestic	11. BIRTHPLACE (State or foreign country) Clark Co. Va.
12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Herrod Hough		14. MOTHER'S MAIDEN NAME Mollie Wilson	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (For, no or unknown) No		16. SOCIAL SECURITY NO. None	17. INFORMANT Harold S. Near
		Address Fairplay R.D.#1	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		CEREBRAL VASCULAR HEMORRHAGE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS	
(b) DUE TO HYPERTENSIVE ARTERIOSCLEROTIC HEART DISEASE		UNKNOWN	
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) NONE		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from MAY 1, 1953, 19____, to OCT. 20, 1958, that I last saw the deceased alive on OCT. 20, 1958, and that death occurred at 7:40 PM, from the causes and on the date stated above. ACTUAL SIGNATURE <i>Archie Robert Cohen</i> M.D. PHYSICIAN'S NAME (Type) Archie R. Cohen M.D. ADDRESS (Street, city or town, state) 101 Cumberland St. Clearspring Md. DATE SIGNED 10/21/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10-22-58	22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery
22d. LOCATION (City, town, or county) Hagerstown		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc. Hagerstown, Md.		24a. REC'D. BY REGISTRAR OCT 23 1958	24b. REGISTRAR'S SIGNATURE <i>John S. Miller</i>



11814

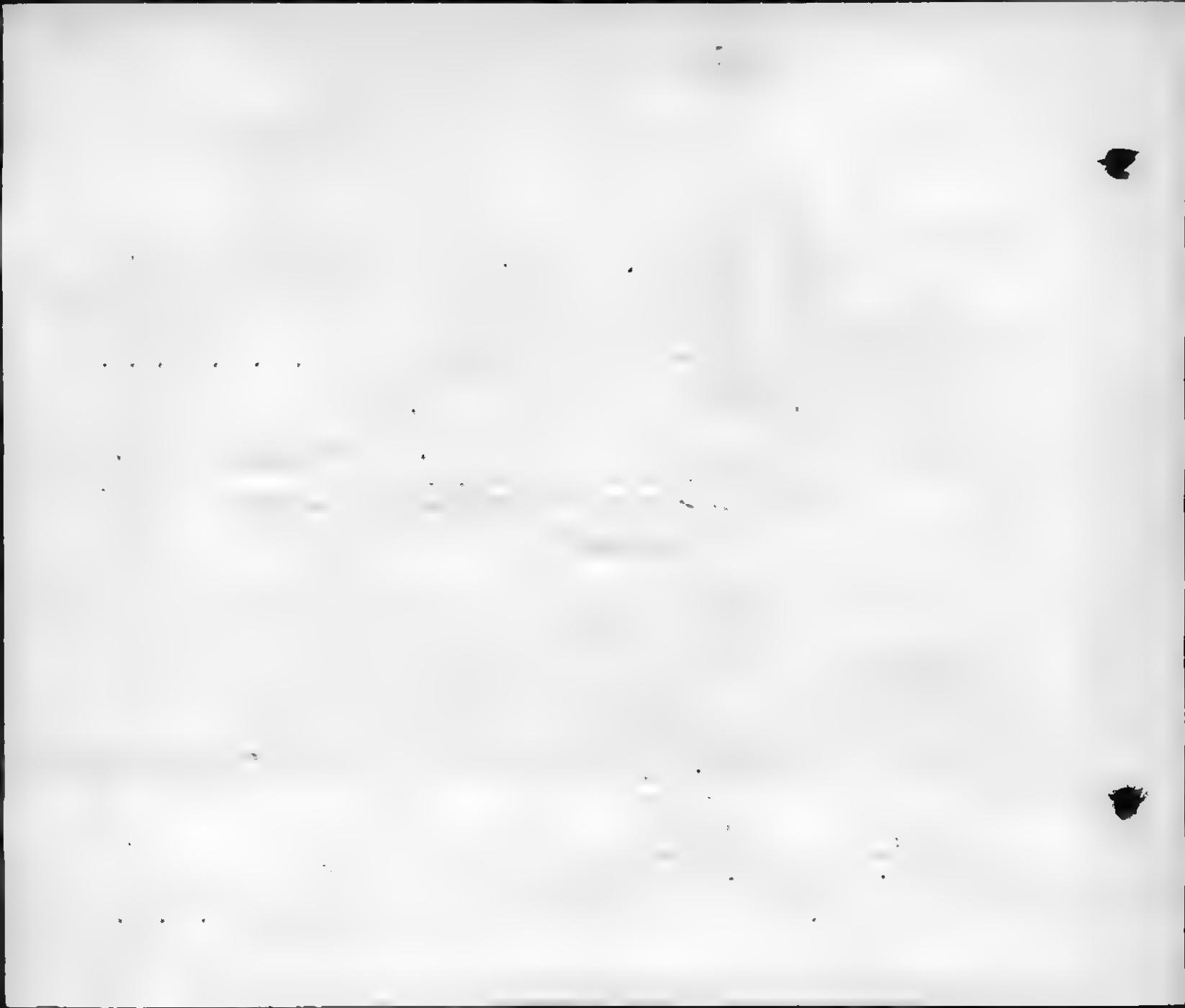
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm P.M.3. Page 5 may be retained for 48 hours. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		11840		2. USUAL RESIDENCE (Where deceased lived if institution, residence before admission)		3. STATE b. COUNTY	
WASHINGTON		MARYLAND		MARYLAND		WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN fb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		d. STREET ADDRESS	
BOONSBORO		LIFE		BOONSBORO		SOUTH MAIN STREET	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)							
SOUTH MAIN STREET							
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	4. DATE OF DEATH	Month	Year
MYRA		J.			OCTOBER	4	1958 19
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years from birthday)	10. IF UNDER 14 YEARS Months Days Hours Min	
FEMALE		WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	AUGUST 30 1887	71 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
HOUSE KEEPER		OWN HOME		BOONSBORO WASH.CO.MD.		U.S.A.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		Address			
GEORGE W. NYMAN		SARAH HOUPP					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))	
NO		NONE		CHARLES F. WAGAMAN HAGERSTOWN MD.		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)				DUE TO <i>extreme exhaustion heart disease</i>	
		(c)				DUE TO <i>Diabetes</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Hour o. m. p. m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>Dr. E.W. Dittler</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) <i>Dr. E.W. Dittler</i>		DATE SIGNED <i>10/7/58</i>					
22a. BURIAL CREMATION REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORIAL		22d. LOCATION (City, town, or county)	
ENTOMBMENT OCT. 7 1958				BOONSBORO MAUSOLEUM		BOONSBORO WASH.CO.MD.	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John B. Bost</i>		ADDRESS <i>Boonsboro Md</i>		24a. REC'D BY REGISTRAR DATE OCT 9 '58		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11815

11800 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN lb 17 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
3. NAME OF DECEASED (Type or print) First MIDDLE LAST WILLIAM COLUMBUS O'NEAL		4. DATE OF DEATH Month October Day 8 Year 1958	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/18/1888
9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED SALESMAN		10b. KIND OF BUSINESS OR INDUSTRY FOOD PRODUCTS	
10c. MOTHER'S NAME WILLIAM C. O'NEAL		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME SARAH MORGAN	
14. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or date of service) NO		15. SOCIAL SECURITY NO. 214-05-8408 16. INFORMANT MRS. ANGIE W. O'NEAL	
17. ADDRESS HAGERSTOWN MD.		18. CAUSE OF DEATH [Enter only one cause per line (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Pulmonary edema 22X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Syphilitic Aortitis (c)	
19. INTERVAL BETWEEN ONSET AND DEATH 1 hr.		20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Cancer of colon, Anemia	
21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 8 Aug. 1958 to 8 Oct. 1958		20c. TIME OF INJURY Month Day Year Hour a. m. 19 p. m.	
20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, form, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>8 Aug. 1958</u> to <u>8 Oct. 1958</u> that I last saw the deceased alive on <u>8 Oct. 1958</u> , and that death occurred at <u>8 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) Richard T. BINFORD, M.D.		22. ACTUAL SIGNATURE Richard T. BINFORD, M.D.	
23. PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M. D.		24. DATE SIGNED 10 Oct. 1958	
22a. BURIAL, CREMATION: BURIAL		22b. DATE THEREOF 10/11/58	
22c. NAME OF CEMETERY OR CREMATORIUM ROSE HILL CEM.		22d. LOCATION (City, town, or county) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Norment, Hagerstown, Md.		24a. REC'D BY REGISTRAR DATE OCT 14 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11841

CERTIFICATE OF DEATH

11816

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE West Virginia b. COUNTY Jefferson	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Gateway, Md		c. LENGTH OF STAY IN 1b 7 Days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Gateway Nursing Home		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Shepherdstown, W Va	
3. NAME OF DECEASED (Type or print) James William Osbourn		4. DATE OF DEATH Oct. 16 Month Day Year 1958	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> b. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> April 1, 1871	9. AGE (In years last birthday) 87 yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Construction	11. BIRTHPLACE (State or foreign country) Jeff. Co., W. Va.
13. FATHER'S NAME George W. Osbourn		14. MOTHER'S MAIDEN NAME Margaret Donley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no, or unknown) If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	17. INFORMANT Kenneth P. Osbourn Address Shepherdstown, W Va
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Acute Broncho Pneumonia 3 days 47-4 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Chr. Valvular Dis 2 yrs. 491X (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 491X		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Oct 13, 1958 to Oct 16, 1958, that I last saw the deceased alive on Oct 16, 1958, and that death occurred at 4:40 PM, from the causes and on the date stated above.		ADDRESS (Street or town, state) DATE SIGNED ACTUAL SIGNATURE David R. Brewer M.D. Clear Spring Md 10/18/58 PHYSICIAN'S NAME (Type) David R. Brewer	
22a. BURIAL, CREMATON, REMOVAL (Specify) Burial Oct. 19, 1958		22b. DATE THEREOF Oct. 19, 1958	22c. NAME OF CEMETERY OR CREMATORIUM Edgewood Cemetery
22d. LOCATION (City, town, or county) Shepherdstown, W Va		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE Melvin F. Strader Charles Town W Va		24a. REC'D BY REGISTRAR OCT 24 '58	24b. REGISTRAR'S SIGNATURE Oct 24 '58



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11801

CERTIFICATE OF DEATH

11817
2

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 507 Jefferson Street		d. STREET ADDRESS 507 Jefferson Street	
3. NAME OF DECEASED (Type or print) FRANK		4. DATE OF DEATH October 26, 1958	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH November 5, 1875
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Tavern Operator		10b. KIND OF BUSINESS OR INDUSTRY Own Business	11. BIRTHPLACE (State or foreign country) Vitiguso, Italy
13. FATHER'S NAME Joseph Papa		14. MOTHER'S MAIDEN NAME Giovanna Rossi	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If no, or unknown no)		16. SOCIAL SECURITY NO none	17. INFORMANT Adolphus Papa
		Address Hagerstown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 201X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause, if any. (b) DUE TO Hodgkin Disease		INTERVAL BETWEEN ONSET AND DEATH 6 mo	
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 9-22-1958 to 10-26-1958, that I last saw the deceased alive on 10-20-58, and that death occurred at 2A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE N. E. Papa		ADDRESS (Street, city or town, state) Hagerstown, Md.	
PHYSICIAN'S NAME (Type) Dr. E. W. D. T. Jr.		DATE SIGNED 10/27/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 10/29/1958	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery	22d. LOCATION (City, town, or county) (State) Hagerstown, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Rouzer Funeral Home R. Franklin Rouzer		ADDRESS Hagerstown, Md.	
		24a. REC'D BY REGISTRAR DATE OCT 29 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

1
FOR STATE
HEALTH DEPT.
1
1
1
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained by the Health Board.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11818

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b D.O.A.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 604 Brighton Place	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Washington County Hospital				e. DATE OF DEATH October		f. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
g. FIRST Arnold		MIDDLE Lee		h. PAYNE		i. DAY 14	
j. MONTH Year 1958							
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 16, 1918	9. AGE (In years last birthday) 39 yrs.	10. IF UNDER 1 YEAR Mo. 11 Days 28	11. IF UNDER 24 HRS Hours 8 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Custodial Officer		10b. KIND OF BUSINESS OR INDUSTRY Reformatory		11. BIRTHPLACE (State or foreign country) Martinsburg, W. Virginia		12. CITIZEN OF WHAT COUNTRY? U.A.S.	
13. FATHER'S NAME James C. Payne		14. MOTHER'S MAIDEN NAME Minnie Freeze					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W. Va. II 215-26-1721		17. INFORMANT Mrs. Mary Payne		Address Hagerstown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1		DUE TO (b)		Acute Coronary Occlusion		INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)		DUE TO (b) (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) none					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. none 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED 10-15-58	
EXAMINER'S NAME (Type) S. Robert Wells, M.D.							
22a. BURIAL, CREMATION REMOVAL (Specify) Burial		22b. DATE THEREOF 10/17/1958		22c. NAME OF CEMETERY OR CREMATORIAL Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown	
						(State) Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Mouzer Funeral Home R. Franklin Lane		ADDRESS Hagerstown, Maryland		24a. REC'D BY REGISTRAR DATE OCT 20 1958		24b. REGISTRAR'S SIGNATURE R. Franklin Lane	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,

page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11803

CERTIFICATE OF DEATH

11820

Reg. Dist. No. 312

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE New Jersey		b. COUNTY Cape May													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 27 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ocean City															
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital		d. STREET ADDRESS 1341 West Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
3. NAME OF DECEASED (Type or print) William		First CRAIG	Middle RAYNOR	4. DATE OF DEATH Oct 30 1958	Month Oct	Day 30	Year 1958												
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 31 1868	9. AGE (in years (last birthday) 90 yrs	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months 0 Days 0 Hours 0 Min 0													
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofer		10b. KIND OF BUSINESS OR INDUSTRY self employed		11. BIRTHPLACE (State or foreign country) Pennsylvania		12. CITIZEN OF WHAT COUNTRY? U.S.A.													
13. FATHER'S NAME William Raynor		14. MOTHER'S MAIDEN NAME Sarah Ann Riley																	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) No		16. SOCIAL SECURITY NO NONE		17. INFORMANT Gertrude Leptich		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), or (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. Hypertensive Cardio Vascular Disease DUE TO (c)													
						INTERVAL BETWEEN ONSET AND DEATH 40 yrs													
19. MEDICAL CERTIFICATION		PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from 10/19/58 to 10-30-58 , that I last saw the deceased alive on 10-29-58 , and that death occurred at 12:30A M, from the causes and on the date stated above. ACTUAL SIGNATURE Searl Young M.D. ADDRESS (Street, city or town, state) 148 M. Potomac DATE SIGNED 10-30-58 NAME (Type) SEARL YOUNG M.D. HAGERS TOWN, MD		20g. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 10/30/58		22c. NAME OF CEMETERY OR CREMATORIAL Mulligan Crematory		22d. LOCATION (City, town, or county) Philadelphia		(State) Penna											
23. FUNERAL DIRECTOR'S SIGNATURE John S. Young Jr.		ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR DATE NOV 3 '58		24b. REGISTRAR'S SIGNATURE John S. Young													



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11842 CERTIFICATE OF DEATH

11821

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Md.		b. COUNTY Frederick			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Boonsboro		c. LENGTH OF STAY IN 1b year		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Middletown		10/-			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH	Month	Day	Year	
Lorenzo Martin Reeder					10	24	1958		
5. SEX male	6. COLOR OR RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH 9/5/1877	9. AGE (In years 81 yrs lost birthday)	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours	Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) farm owner, ret.		10b. KIND OF BUSINESS OR INDUSTRY farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.			
13. FATHER'S NAME Josephus Reeder		14. MOTHER'S MAIDEN NAME Mary Ann Beer		Address					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Mrs. Bessie Reeder, Boonsboro, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>adeno Carcinoma stomach</i>			INTERVAL BETWEEN ONSET AND DEATH 2 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause first.		(b) DUE TO							
(c) DUE TO									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>generalized arteriosclerosis, Senility</i>									19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)							
20c. TIME OF INJURY Month, Day, Year Hour e. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)
21. I certify that I attended the deceased from <i>Mar 28, 1958</i> , to <i>Oct 24, 1958</i> , that I last saw the deceased alive on <i>Oct 24, 1958</i> , and that death occurred at <i>2:30 PM</i> , from the causes and on the date stated above.									
ACTUAL SIGNATURE <i>Robert V. L. Campbell M.D.</i> ADDRESS (Street, city or town, state) <i>145 W. Washington St 10/24/58</i> DATE SIGNED <i>10/24/58</i>									
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 10/27/1958		22c. NAME OF CEMETERY OR CEMETORY Reformed Cemetery		22d. LOCATION (City, town, or county) Middletown		(State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Gladhill Co., Middletown, Md.		ADDRESS		24a. REC'D. BY REGISTRAR OCT 28 58		24b. REGISTRAR'S SIGNATURE C. Lewis S. Krause			



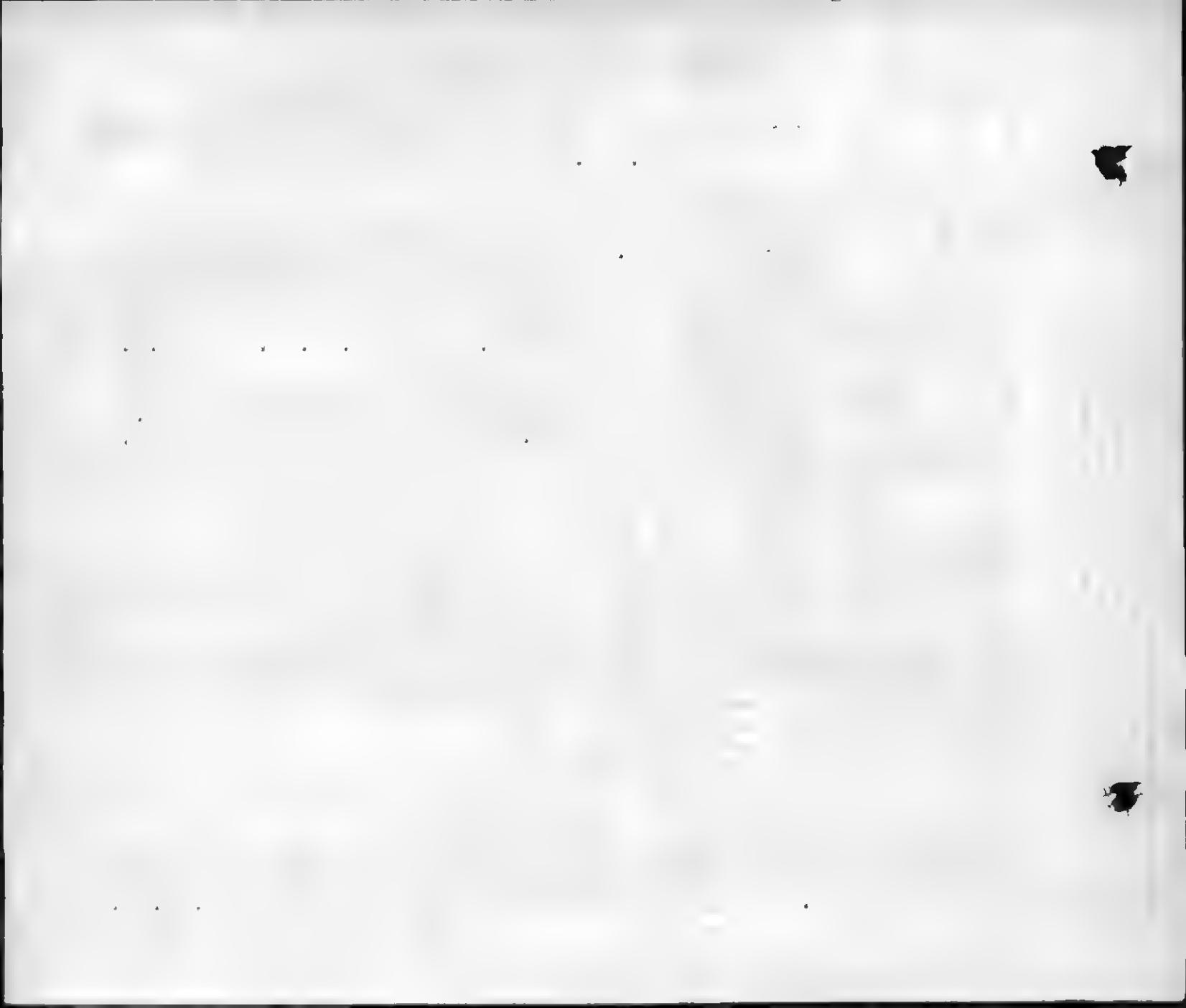
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11822

11843 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BOONSBORO		c. LENGTH OF STAY IN 1b 3 YR. 6MO.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION REEDER NURSING HOME		d. STREET ADDRESS 104 ALLEN AVENUE		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First VIRGIE	Middle M.	Last REESE	4. DATE OF DEATH	Month OCTOBER	Day 15	Year 1958
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH AUGUST 3 1884	9. AGE (In years from birthday) 74	IF UNDER 1 YEAR Months 7	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b. KIND OF BUSINESS OR INDUSTRY OWN HOME		11. BIRTHPLACE (State or foreign country) MT. LENA WASH. CO. MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME CORNELIUS HOUP			14. MOTHER'S MAIDEN NAME AMANDA (NO RECORD)				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) NO		16. SOCIAL SECURITY NO NONE		17. INFORMANT MRS. RHODA WEIGAND		104 ALLEN AVE. HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per box for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cornelia Houp</i> DUE TO <i>400.0</i> INTERVAL BETWEEN Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>400.0</i> (c) <i>1958-10-15</i> DUE TO <i>400.0</i>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b) 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 20d. INJURY OCCURRED at work <input type="checkbox"/> Not at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) <i>Boonsboro</i> (County) <i>Wash. Co.</i> (State) <i>Md.</i>					
21. I certify that I attended the deceased from <i>June 3, 1958</i> to <i>Oct. 15, 1958</i> , that I last saw the deceased alive on <i>October 15, 1958</i> , and that death occurred at <i>Boonsboro</i> M. from the causes and on the date stated above. ACTUAL SIGNATURE <i>G. W. LeVan</i> ADDRESS <i>Boonsboro</i> DATE SIGNED <i>10-17-58</i> PHYSICIAN'S NAME (Type) <i>G. W. LeVan</i> M.D. <i>Boonsboro</i> <i>10-17-58</i> 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL 22b. DATE THEREOF OCT. 18 1958 22c. NAME OF CEMETERY OR CREMATORIUM BOONSBORO CEMETERY 22d. LOCATION (City, town, or county) BOONSBORO WASH. CO. MD.							
23. FUNERAL DIRECTOR'S SIGNATURE <i>John H. Bost Boonsboro Md.</i>				24a. REC'D BY REGISTRAR DATE OCT 22 '58		24b. REGISTRAR'S SIGNATURE <i>Cirrus S. Knott</i>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

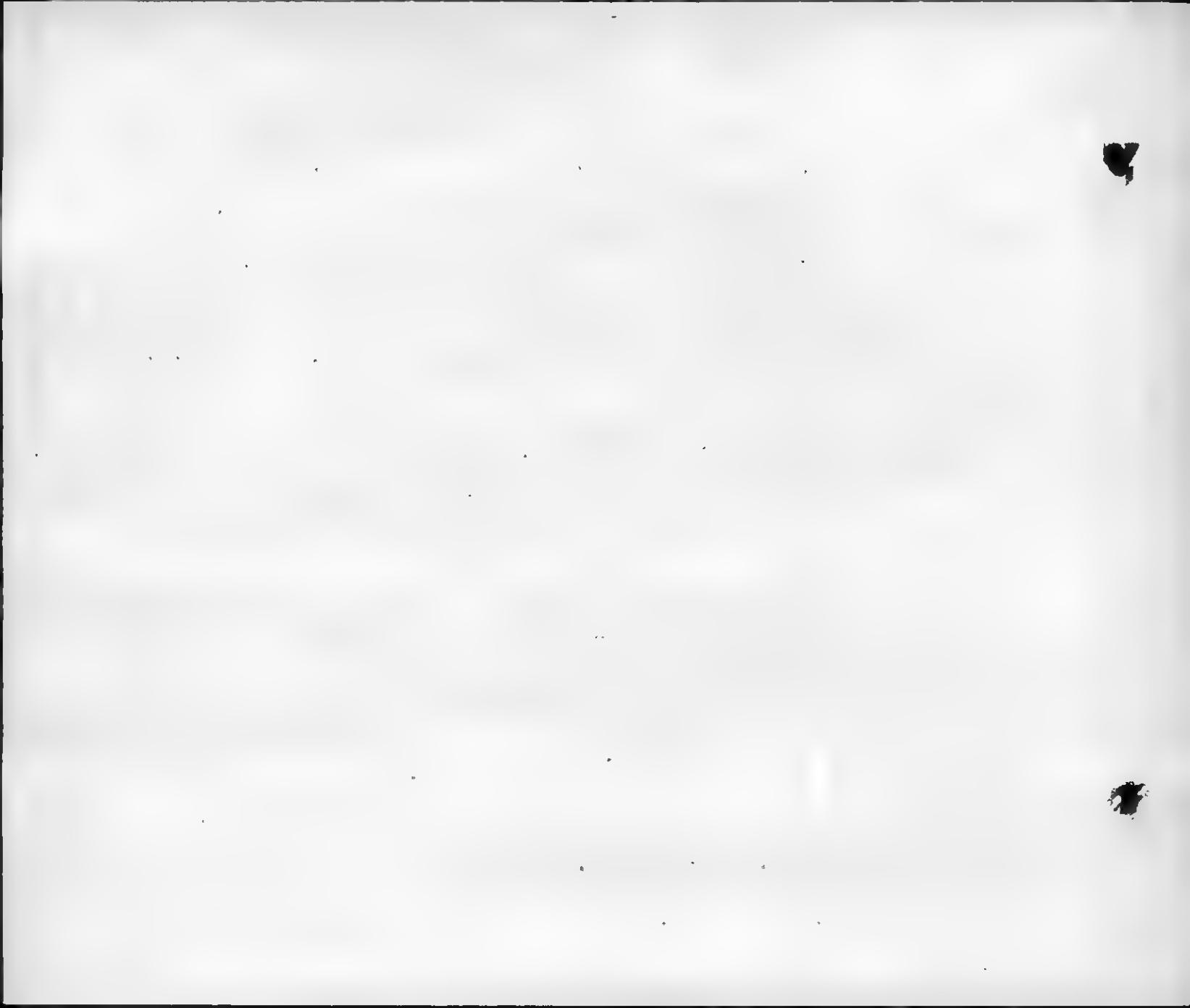
11844

CERTIFICATE OF DEATH

11823

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived, if institutional, Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Sharpsburg Md.		c. LENGTH OF STAY IN 1b 4 yrs.				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION South Mechanic Street		d. STREET ADDRESS South Mechanic Street				
3. NAME OF DECEASED (Type or print) Ivan		First Jacob	Middle Renner			
4. SEX Male	5. COLOR OR RACE White	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	7. DATE OF BIRTH June 21 1888			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd Painter		10b. KIND OF BUSINESS OR INDUSTRY House Painter	11. BIRTHPLACE (State or foreign country) Sharpsburg Md.			
13. FATHER'S NAME Jacob Renner		14. MOTHER'S MAIDEN NAME Alice Bowers				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 165 12 7600	17. INFORMANT Mrs. Bertha Poffenbarger Sharpsburg Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Arteriosclerotic heart disease - Cerebral 5 yr DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH found dead instantly				
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Nasal bleeding for 2 weeks - possible blood dyscrasia		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 1b.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Sharpsburg	(County)	(State)
21. I certify that I attended the deceased from Sep. 9/26/58 to 10/6/58 alive on 10/3/58 19 and that death occurred at 8 A. M., from the causes and on the date stated above		ADDRESS (Street, city or town, state) Sharpsburg, Md.		DATE SIGNED 10/9/58		
ACTUAL SIGNATURE <i>Walter H. Shealy</i>		PHYSICIAN'S NAME (Type) Walter H. Shealy M. D.				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 9 1958	22c. NAME OF CEMETERY OR CREMATORIAL Mt. View Cemetery	22d. LOCATION (City, town, or county) Sharpsburg Maryland		
23. FUNERAL DIRECTOR'S SIGNATURE, <i>Albert L. K. Williamsport, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 10 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Thoms	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be examined within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

THIS MAN ALSO **11845** MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
SPELLED HIS NAME ROBISON

CERTIFICATE OF DEATH

Reg. Dist. No. **11824**

1. PLACE OF DEATH a. COUNTY WASHINGTON		MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE MARYLAND		b. COUNTY WASHINGTON		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEAR SPRING		c. LENGTH OF STAY IN 1b Minutes		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BIG SPRING ROUTE 2		d. STREET ADDRESS NONE		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION C. BERLAND STREET				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) GORDON DAYTON ROBINSON		First	Middle	Lost	4. DATE OF DEATH OCT.	Month	Day	Year
5. SEX MALE		6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH DEC. 22, 1893	9. AGE (In years last birthday) 64	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	Hours
10a. US/AL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER		10b. KIND OF BUSINESS OR INDUSTRY FARI.		11. BIRTHPLACE (State or foreign country) CLEAR SPRING, U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME CYRUS D. ROBINSON		14. MOTHER'S MAIDEN NAME SARA E. RILEY						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. WORLD WAR I		17. INFORMANT NONE		Address MRS FLORENCE ROBINSON		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c)		Acute Coronary Occlusion Rheumatic Heart Dis.				INTERVAL BETWEEN ONSET AND DEATH Sudden 5 yrs.		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from May 15 1958 to Oct 18 1958 , that I last saw the deceased alive on Oct 18, 1958 , and that death occurred at 9:30 AM , from the causes and on the date stated above. ACTUAL SIGNATURE David R. Brewer M.D.				ADDRESS (Street, city, or town, state) Clear Spring Md.		DATE SIGNED 10/20/58		
22a. BURIAL, CREMATION, REMOVAL (Specify) Shanktown		22b. DATE THEREOF OCT. 22, 1958		22c. NAME OF CEMETERY OR CREMATORIAL SHANKTOW		22d. LOCATION (City, town, or county) SHANKTOWN		(State) MARYLAND
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark		ADDRESS CLEAR SPRING, MD.		24a. REC'D BY REGISTRAR DATE OCT 24 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Traas		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11804

CERTIFICATE OF DEATH

11825

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington MARYLAND			2. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) a. STATE Maryland b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hawthorne, Md.			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hawthorne, Md.		
c. LENGTH OF STAY IN 1b 6 days			d. STREET ADDRESS 1418 W. Washington St.		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print)	First Ernest	Middle Edward	Last Rubeck	4. DATE OF DEATH Oct. 18 1958	Month Oct.
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 9 1938	9. AGE (in years last birthday) 20 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 2 Days 8 Hours 0 Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Cabinet Works		11. BIRTHPLACE (State or foreign country) Clearspring Md. RFD1	
13. FATHER'S NAME Lester Andrew Rubeck			14. MOTHER'S MAIDEN NAME Hazel Timmons		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 215 34 3668		17. INFORMANT Mr. Lester Rubeck	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Hemorrhage (Sub arachnoid) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Congenital aneurysm (cerebral) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) No					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10/12 1958 to 10/17 1958, that I last saw the deceased alive on 10/17 1958, and that death occurred at 8:30 AM, from the causes and on the date stated above ACTUAL SIGNATURE <i>Louis G. Grafton</i> ADDRESS (Street, city or town, state) <i>119 E. Main Street</i> DATE SIGNED <i>10/18/58</i>					
22a. BURIAL, CREMATION, REMOVAL (Specify) Urns		22b. DATE THEREOF Oct. 21-58		22c. NAME OF CEMETERY OR CREMATORIAL Blairs Valley Cemetery	
22d. LOCATION (City, town, or county) (State)		22e. LOCATION (City, town, or county) Clearspring Md. R. F. D.		22f. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Arthur S. Thompson, Md.</i>		ADDRESS		24a. REC'D BY REGISTRAR OCT 21 '58	
24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thompson</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be submitted within 24 hours after death. Page 4
may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use in the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G235 10-21-58 et

11805

CERTIFICATE OF DEATH

11826

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Prince George		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown, Md.		c. LENGTH OF STAY IN 1b Nov. 11, 1957		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Ranier		d. STREET ADDRESS 3109 Window Road		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
3. NAME OF DECEASED (Type or print) Ryman, Homer K		First	Middle	Last	4. DATE OF DEATH Oct 32	Month	Day	Year 1958
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 20, 1871	9. AGE (In years lost birthday) 86 yrs.	10. IF UNDER 1 YEAR OR IF UNDER 24 HRS. Months Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY on farm		11. BIRTHPLACE (State or foreign country) Shenandoah, Va.		12. CITIZEN OF WHAT COUNTRY? U. S.		
13. FATHER'S NAME William Ryman				14. MOTHER'S MAIDEN NAME Elizabeth Kaufman				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT Hospital record		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure						INTERVAL BETWEEN ONSET AND DEATH 24 hours		
44u.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arteriosclerotic heart disease						Nov. 1951		
DUE TO (c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Gangrene, left lower leg						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. s. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Name, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Sept. 30, 1958 to Oct. 12, 1958 that I last saw the deceased alive on Oct. 12, 1958 , and that death occurred at 3:30 PM , from the causes and on the date stated above. ACTUAL SIGNATURE <i>J. H. Kehne, M.D.</i>		M.D.		ADDRESS (Street, city or town, state)		DATE SIGNED		
PHYSICIAN'S NAME (Type) J. H. Kehne, M. D.		131 W. Washington St., Hagerstown, Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct 14-58		22c. NAME OF CEMETERY OR CREMATORIAL Longmeadow		22d. LOCATION (City, town, or county) (State) Boonsboro		
23. FUNERAL DIRECTOR'S SIGNATURE William B. Histon, Barnesville, Md.		24a. REC'D BY REGISTRAR DATE Oct 16 '58						
		24b. REGISTRAR'S SIGNATURE James L. Knott						

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

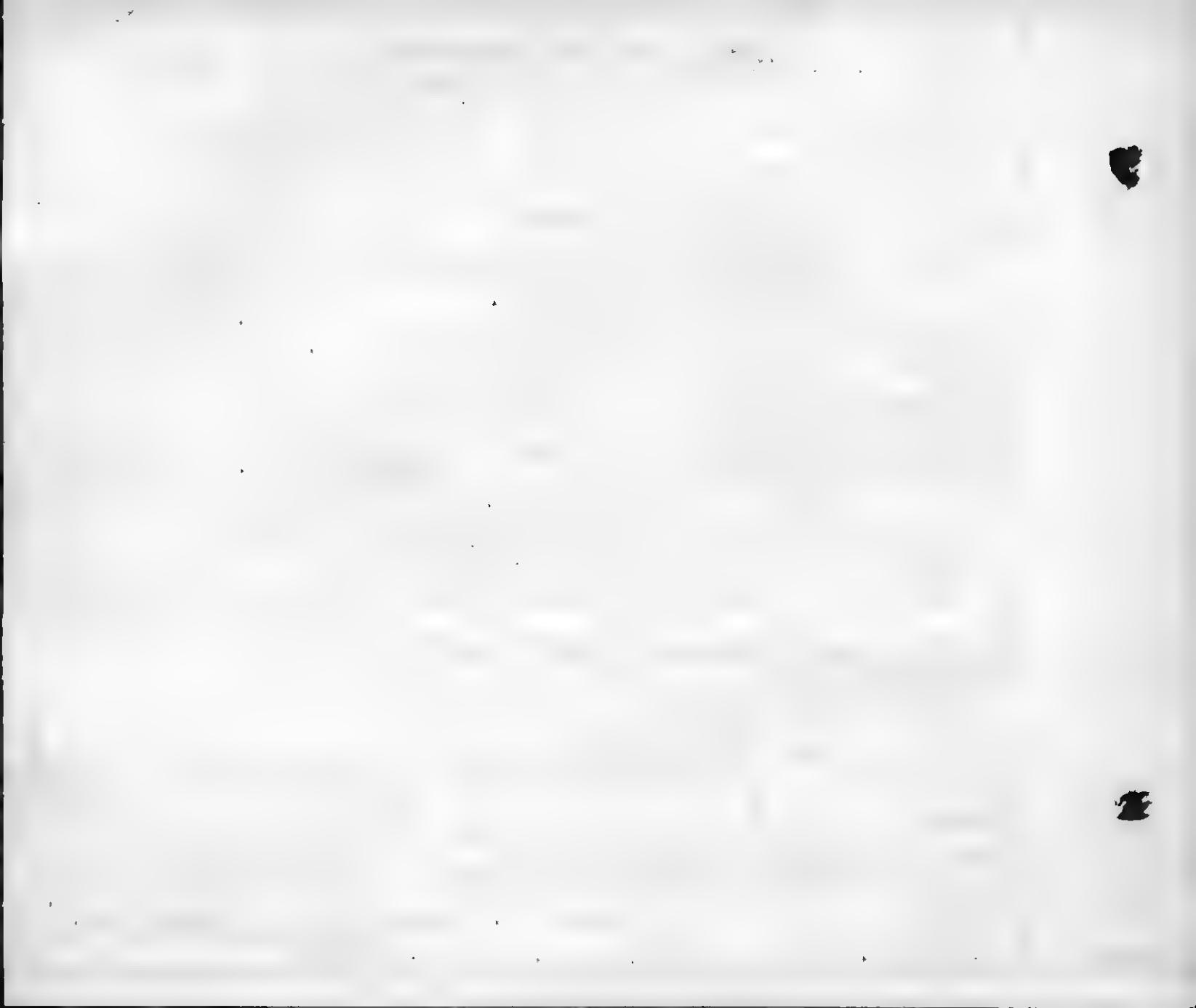
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11827

11806 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 Yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				
d. NAME OF HOSPITAL (If not in hospital, give street address) So Mont Valla Ave				d. STREET ADDRESS 53 So Mont Valla Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) MARY		First JANE	Middle SELLERS	Last	4. DATE OF DEATH October 12	Month 19	Day 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	B. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> Nov. 14 1879	9. AGE (In years last birthday) 78 yrs	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) near Reid Wash. Co		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME Cornelius Myers		14. MOTHER'S MAIDEN NAME Sarah Sweigert						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs Grace Selby 53 So Mont Valla Ave		Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		Hagerstown Md.		Hagerstown Md.		INTERVAL BETWEEN ONSET AND DEATH 1 year		
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		Severe Arterio Sclerotic Heart Disease With myocardial fibrillation						
(c)								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20c. TIME OF INJURY Hour o. m. p. m.		Month 19	Day	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) M.D. 230 N Pittman	20f. (City or town) Hagerstown	(County) Md.	(State)
21. I certify that I attended the deceased from <u>4pm</u> , 19 <u>57</u> , to <u>12 Oct</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>12 Oct</u> , 19 <u>58</u> , and that death occurred at <u>505P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) M.D. 230 N Pittman								
ACTUAL SIGNATURE F. F. Lusby		DATE SIGNED 13 Oct 58						
PHYSICIAN'S NAME (Type) F. F. Lusby		Hagerstown Md.						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/15/58		22c. NAME OF CEMETERY OR CREMATORIAL Long Meadows Ch. Cemetery near Paramount Wash. Co		22d. LOCATION (City, town, or county) Md.		
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Cofman		ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR DATE OCT 17 '58		24b. REGISTRAR'S SIGNATURE C. H. & H. Hause		



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11828

11807

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND		b. COUNTY		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 5 mos - 24 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore		d. STREET ADDRESS 804 BEAM STREET		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WESTERN Md STATE Hospital				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) GARLAND		First	Middle	Lost	4. DATE OF DEATH SEWELL	Month October	Day 19	Year 1958
5. SEX MALE	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH JUNE 6, 1900		9. AGE (In years less birthday) 58	10. IF UNDER 1 YEAR: IF UNDER 24 HRS yrs. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) WEIDER		10b. KIND OF BUSINESS OR INDUSTRY VARIOUS INDUSTRY		11. BIRTHPLACE (State or foreign country) NORTH CAROLINA		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME Richard SEWELL		14. MOTHER'S MAIDEN NAME SUSAN DAVIS						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. 272-07-6939		17. INFORMANT Ada SEWELL		Address Baltimore, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pulmonary Embolism		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		DUE TO Pulmonary Edema and Congestion		INTERVAL BETWEEN ONSET AND DEATH 2 hours		
		(b)				1 day		
		(c)		HYPERTENSIVE CARDIOVASCULAR DISEASE		5 years		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) ARTERIOLOPHTHEMOSIS						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Baltimore	(County) Baltimore (State) Maryland	
21. I certify that I attended the deceased from APRIL 25, 1958 , to OCT. 11, 1958 , that I last saw the deceased alive on OCTOBER 19, 1958 , and that death occurred at 6:30 AM , from the causes and on the date stated above.						ADDRESS (Street, city or town, state) 6:30 AM		
ACTUAL SIGNATURE Evaresto R. Landybal		M.D.		WESTERN Md STATE Hospital		DATE SIGNED 10-18-58		
PHYSICIAN'S NAME (Type) Evaresto R. Landybal		Hagerstown, Md						
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Oct. 23		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Hill Cemetery		22d. LOCATION (City, town, or county) Baltimore		
23. FUNERAL DIRECTOR'S SIGNATURE Al Cofrances		ADDRESS Hagerstown, Md		24a. REC'D BY REGISTRAR OCT 21 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Krause		



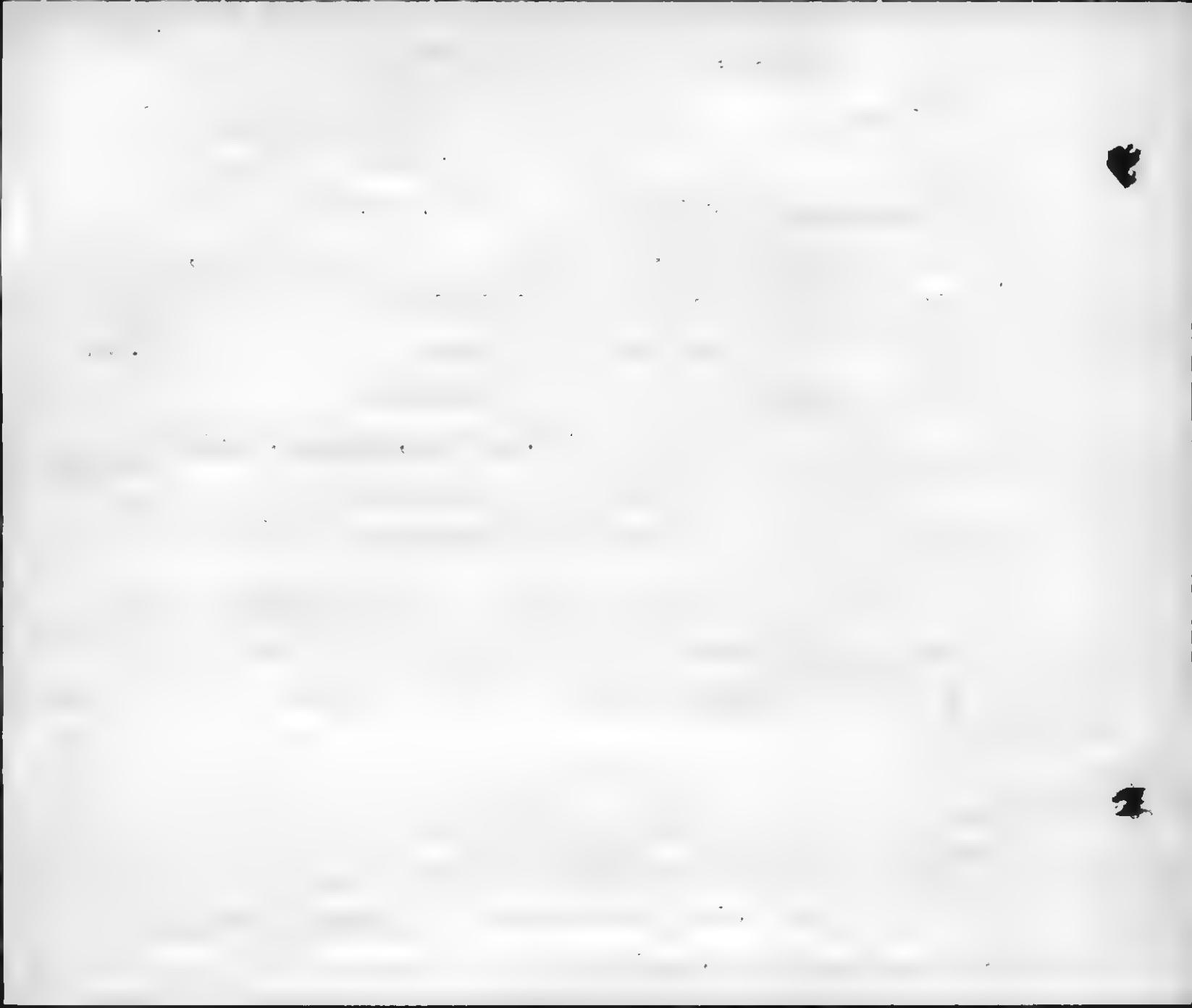
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 Item 2 film G 235 10/30/58 gg
CERTIFICATE OF DEATH

11829
 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY Carroll / Wash.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 1 month		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 716 W. Washington Street	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Emma	Middle L.	Last Smith	4. DATE OF DEATH October 27, 1958	Month Year	Day	Year
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 15, 1873	9. AGE (In years from last birthday) 85	10. IF UNDER 1 YEAR Months 85	11. IF UNDER 24 HRS. Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House work		10b. KIND OF BUSINESS OR INDUSTRY Own home		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY/ U.S.A.	
13. FATHER'S NAME Americus Shoemaker				14. MOTHER'S MAIDEN NAME Mary Crabbs			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.		17. INFORMANT		Address Mrs. Roy Smith, Taneytown, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 170X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), stating the underlying cause (c) Carcinoma Breast in Melinda & Anna & Lois DUE TO 1 year.							
INTERVAL BETWEEN ONSET AND DEATH							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Hagerstown		20f. (City or town) Taneytown	(County) Maryland (State)
21. I certify that I attended the deceased from 9-29-58 , 19 58 , to 10-27 , 19 58 , that I last saw the deceased alive on 10-26-58 , 19 58 , and that death occurred at 7:15 A.M. , from the causes and on the date stated above ADDRESS (Street, city or town, state) Hagerstown, Md. DATE SIGNED 10/27/58							
ACTUAL SIGNATURE R. E. D. D.		M.D. Hagerstown, Md.					
PHYSICIAN'S NAME (Type) H. E. W. H. T. Jr.		Physician's signature Hagerstown, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF October 30, 1958		22c. NAME OF CEMETERY OR CREMATORIAL Reformed Cemetery		22d. LOCATION (City, town, or county) Taneytown, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE C. O. Fuss & Son, Taneytown, Maryland		ADDRESS C. O. Fuss & Son, Taneytown, Maryland		24a. REC'D BY REGISTRAR Oct 28 1958		24b. REGISTRAR'S SIGNATURE C. O. Fuss & Son, Taneytown, Maryland	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

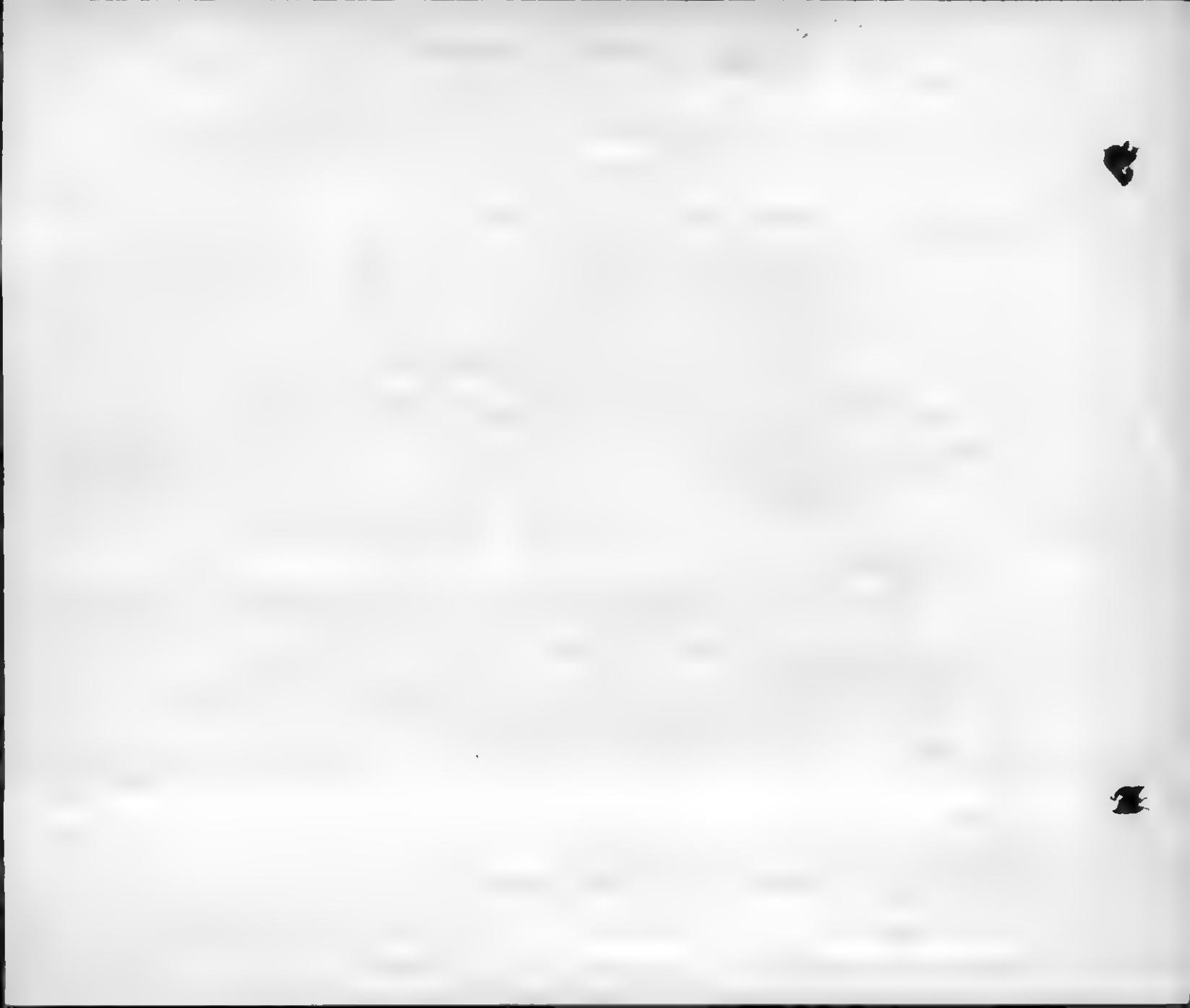
11830

11803

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived if institution- Residence before admission) a. STATE M.D.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		b. COUNTY FREDERICK	
c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MYERSVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASH Co. Hosp.		d. STREET ADDRESS Route #2	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First Raymond	Middle Ray	Last Souders
4. DATE OF DEATH	Month 10	Day 29	Year 1958
5. SEX M	6. COLOR OR RACE W	MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH 10-29-58
7. AGE (In years lost birthday) 100 yrs.	8. IF UNDER 1 YEAR Months 0	9. IF UNDER 24 HRS Days 18	10. Hours 18
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Md.	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Raymond Souders	14. MOTHER'S MAIDEN NAME BETTY REBECCA GREEN	Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO	16. SOCIAL SECURITY NO.	17. INFORMANT	
	none	Mrs. BETTY Souders, Myersville Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Anoxia		INTERVAL BETWEEN ONSET AND DEATH 18 hr.	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Prolapsd umbilical cord			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.	20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
10/29 1958	19		
21. I certify that I attended the deceased from 10/29 , 19 58 , to 10/30 , 19 58 , that I last saw the deceased alive on 10/29 , 19 58 , and that death occurred at 5 A.M., from the causes and on the date stated above ADDRESS (Street, city or town, state) 19 C. Antipian DATE SIGNED Hagerstown, Md. 10/30/58			
ACTUAL SIGNATURE Louis S. Souders	M.D.		
PHYSICIAN'S NAME (Type) Louis S. Souders			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10-30-58	22c. NAME OF CEMETERY OR CREMATORIAL PLEASANT WALK U. B.	22d. LOCATION (City, town, or county) (State) Mr. Myersville, Fred Co. Md.
23. FUNERAL-DIRECTOR'S SIGNATURE Paul J. Birt	ADDRESS Myersville, Md.	24a. REC'D BY REGISTRAR DATE NOV 3 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Krause



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11846 CERTIFICATE OF DEATH

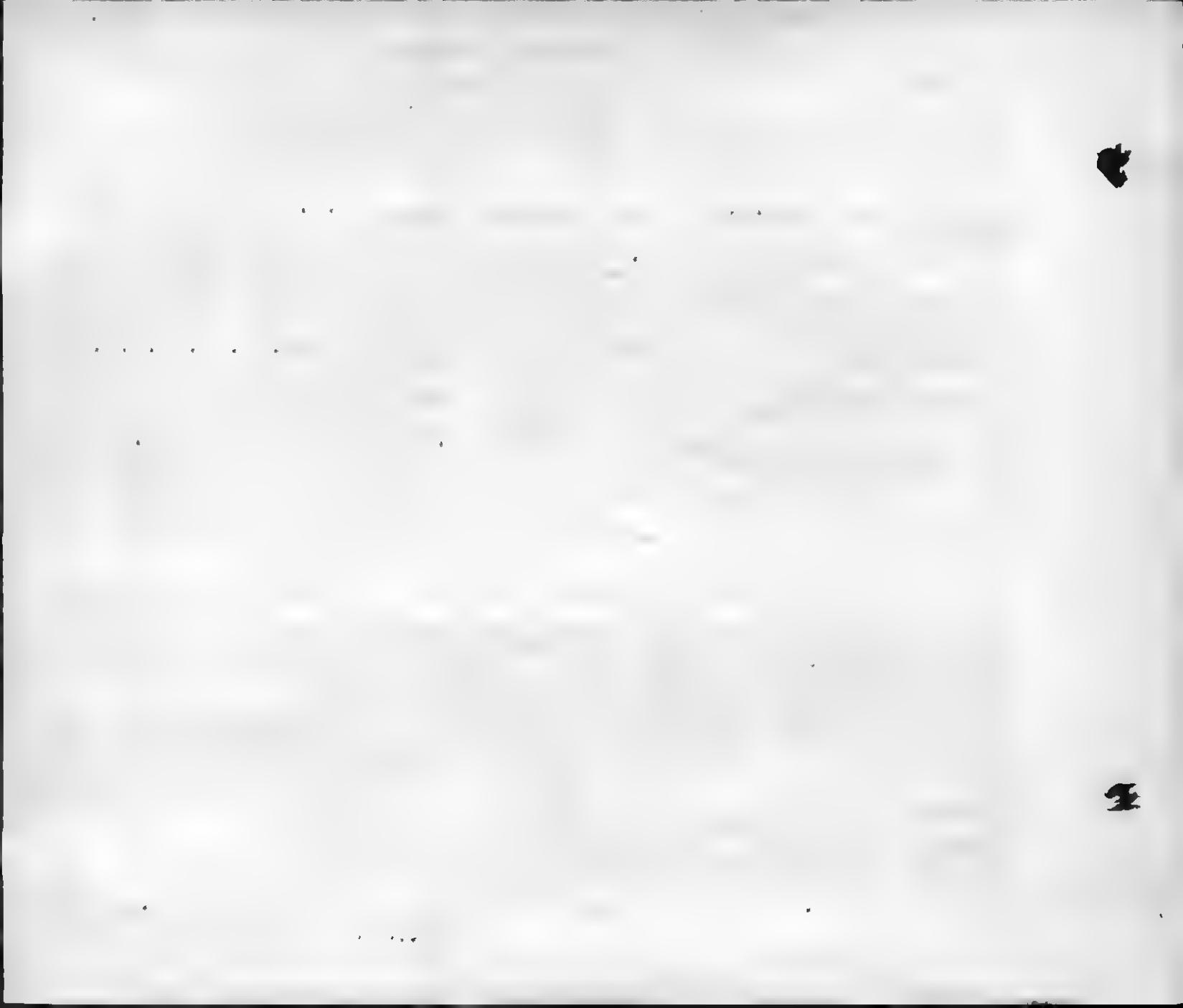
11831

Reg. Dist. No.

1. PLACE OF DEATH ■ COUNTY WASHINGTON		MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) o STATE MARYLAND		b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BEAVER CREEK		c LENGTH OF STAY IN 1b 40 YEARS		c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X BEAVER CREEK			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HAGERSTOWN MD.R.1		d. STREET ADDRESS HAGERSTOWN MD.R. 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First LULA	Middle M.	SPRECHER	4. DATE OF DEATH OCTOBER 3 1958	Month Oct	Doy 3	Year 1958
S. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH DECEMBER 29 1890	9. AGE (In years lost birthday) 67 yrs	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	Hours 0
10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE		10b KIND OF BUSINESS OR INDUSTRY OWN HOME		11 BIRTHPLACE (State or foreign country) LEITERSBURG WASH. CO. MD. U.S.A.		12 CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME ELMER SLICK		14 MOTHER'S MAIDEN NAME MARY SHOWE					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT CHARLES R. SPRECHER GAVETO WN MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)		DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last.		disease Hypertensive Cardio Vascula Arterio - Sclerosis -		INTERVAL BETWEEN ONSET AND DEATH 30 days. 10 yrs 10 yrs	
b)		DUE TO					
c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED White Not white of work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Sept 1</u> , 1958 to <u>Oct 3</u> , 1958, that I last saw the deceased alive on <u>Oct 3</u> , 1958, and that death occurred at <u>10 A.M.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state)					
ACTUAL SIGNATURE G. A. R. O. H. C. R.		DATE SIGNED 10/4/58					
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF OCT. 6 1958		22c. NAME OF CEMETERY OR CREMATORIUM MANOR CEMETERY		22d. LOCATION (City, town, or county) NEAR TILGHMANTON MD. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE John H. Bost Boonsboro Md		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 9 '58		24b. REGISTRAR'S SIGNATURE Clyde S. Evans	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

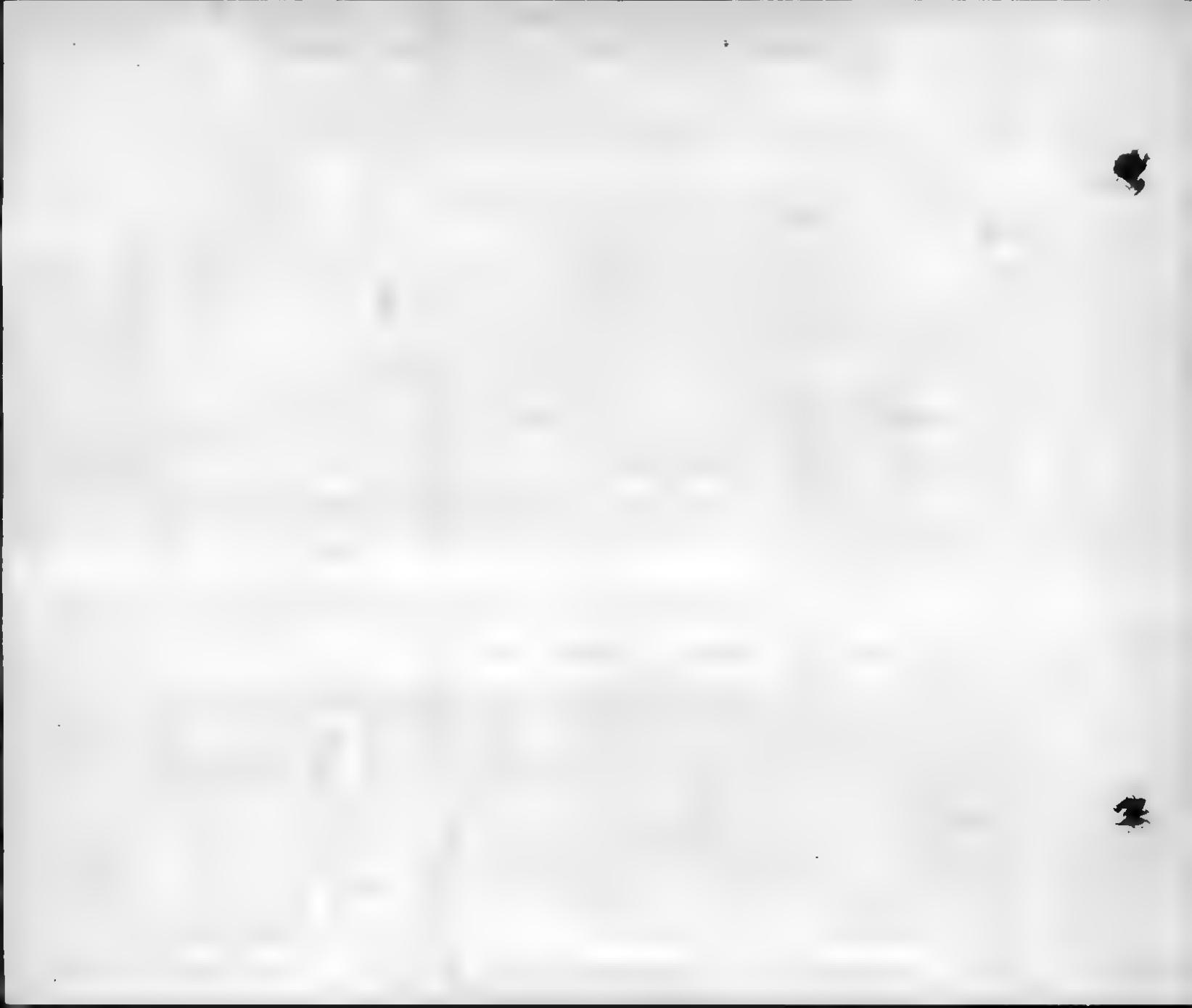
VS. ATIME(S)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11810 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11832

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 3 hrs		2. USUAL RESIDENCE (Where deceased lived if institution; Residence before admission) a. STATE Maryland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Enroute to Washington County Hospital		d. STREET ADDRESS 577 Beechfield Avenue		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) Ralph		First Sears		Middle Stewart		4. DATE OF DEATH Oct. 6		Month Day Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH June 20, 1906	9. AGE (In years last birthday) 52 yrs.	10. IF UNDER 1 YEAR Months 5		11. IF UNDER 24 HRS. Days Hours Min		
10a. USUAL OCCUPATION (Give kind of work done during past of working life, even if retired) Sales Manager		10b. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland		12. CITIZEN OF WHAT COUNTRY? USA			
13. FATHER'S NAME George Stewart				14. MOTHER'S MAIDEN NAME Lurenna Stewart Marsh					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W. W. # 2		17. INFORMANT Branca Eliz. Stewart - wife - Baltimore, Md		Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Advanced arteriosclerotic coronary heart disease				INTERVAL BETWEEN ONSET AND DEATH					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. Acute Coronary thrombosis		DUE TO (b)		DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) none				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. none		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) none							
20c. TIME OF INJURY Hour o. m. p. m.	Month, Day, Year none 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) none	20f. (City or town) —	(County) —	(State) —			
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .									
ACTUAL SIGNATURE <i>S. Robert Wells</i>	M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			DATE SIGNED 10-6-58					
EXAMINER'S NAME (Type) S. Robert Wells, M.D.	22b. DATE THEREOF October 1958								
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22c. NAME OF CEMETERY OR CREMATORIAL Baltimore National Cemetery		22d. LOCATION (City, town, or county) Baltimore, Maryland		(State) —				
23. FUNERAL DIRECTOR'S SIGNATURE John Cook	ADDRESS 1703 Baltimore Avenue		24a. REC'D. BY REGISTRAR Oct 14 '58		24b. REGISTRAR'S SIGNATURE John Cook				



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11811

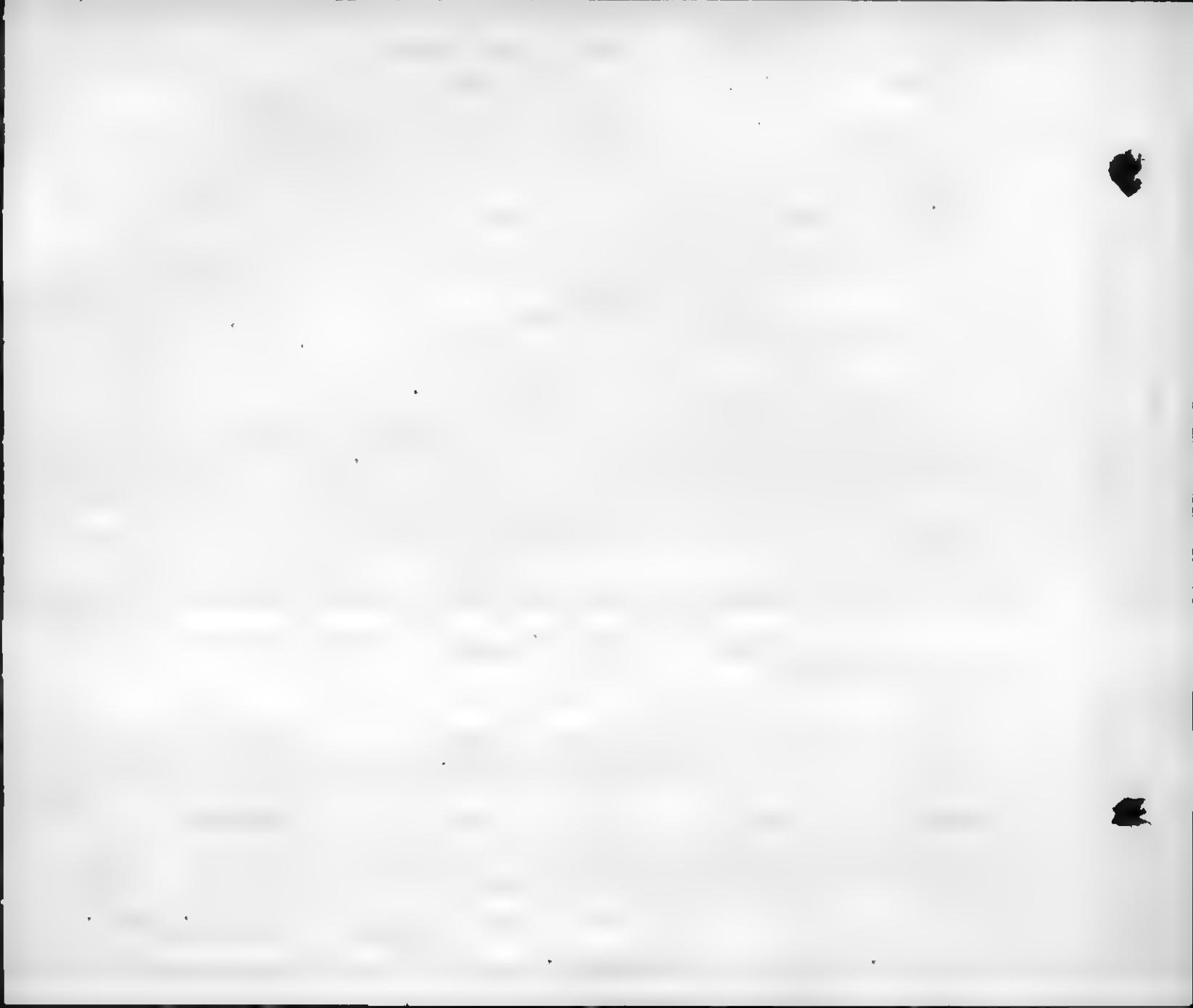
CERTIFICATE OF DEATH

11833

Reg. Dist. No. 302

1. PLACE OF DEATH a. COUNTY shington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 10 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 1666 Fountain Hd Road	
d. NAME OF HOSPITAL (If not in hospital, give street address) ASH. COUNTY HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First VICTOR	Middle FRANCIS	Last STINE	4. DATE OF DEATH	Month Oct 29	Day 1958	Year 19
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH May 2 1893	9. AGE (In years last birthday) 5 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS Days 0	IF UNDER 24 HRS Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) President Pangborn Corp		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Sharpsburg Wash. Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Daniel Stine		14. MOTHER'S MAIDEN NAME Mary K. Munson					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown)		16. SOCIAL SECURITY NO 214-09-5985		17. INFORMANT Doris Bennett 1664 Fountain Hd. Rd Hagerstown Md.		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0		DUE TO Pulmonary Edema		INTERVAL BETWEEN ONSET AND DEATH minutes			
Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b)		DUE TO Arteriosclerotic Heart Disease		3 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) Benign Prostatic Hypertrophy with Retention		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg. etc.)		20f. (City or town) (County) (State)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.							
21. I certify that I attended the deceased from 1-30-, 1958, to 10-29-, 1958, that I last saw the deceased alive on 10-29-, 1958, and that death occurred on 10-29-, 1958, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE DALTON M. WELTY M.D. Hagerstown, Maryland 10-30-58 PHYSICIAN'S NAME (Type) DALTON M. WELTY							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/31/58		22c. NAME OF CEMETERY OR CREMATORIUM Rest Haven Cemetery		22d. LOCATION (City, town, or county) Hagerstown Wash. Co Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman Hagerstown Md.		ADDRESS		24a. REC'D. BY REGISTRAR ROV 3 '58 DATE		24b. REGISTRAR'S SIGNATURE C. J. COFFMAN	

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, signed by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2, to be filed with the registrar prior to burial, cremation, or removal, and in any event within 24 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

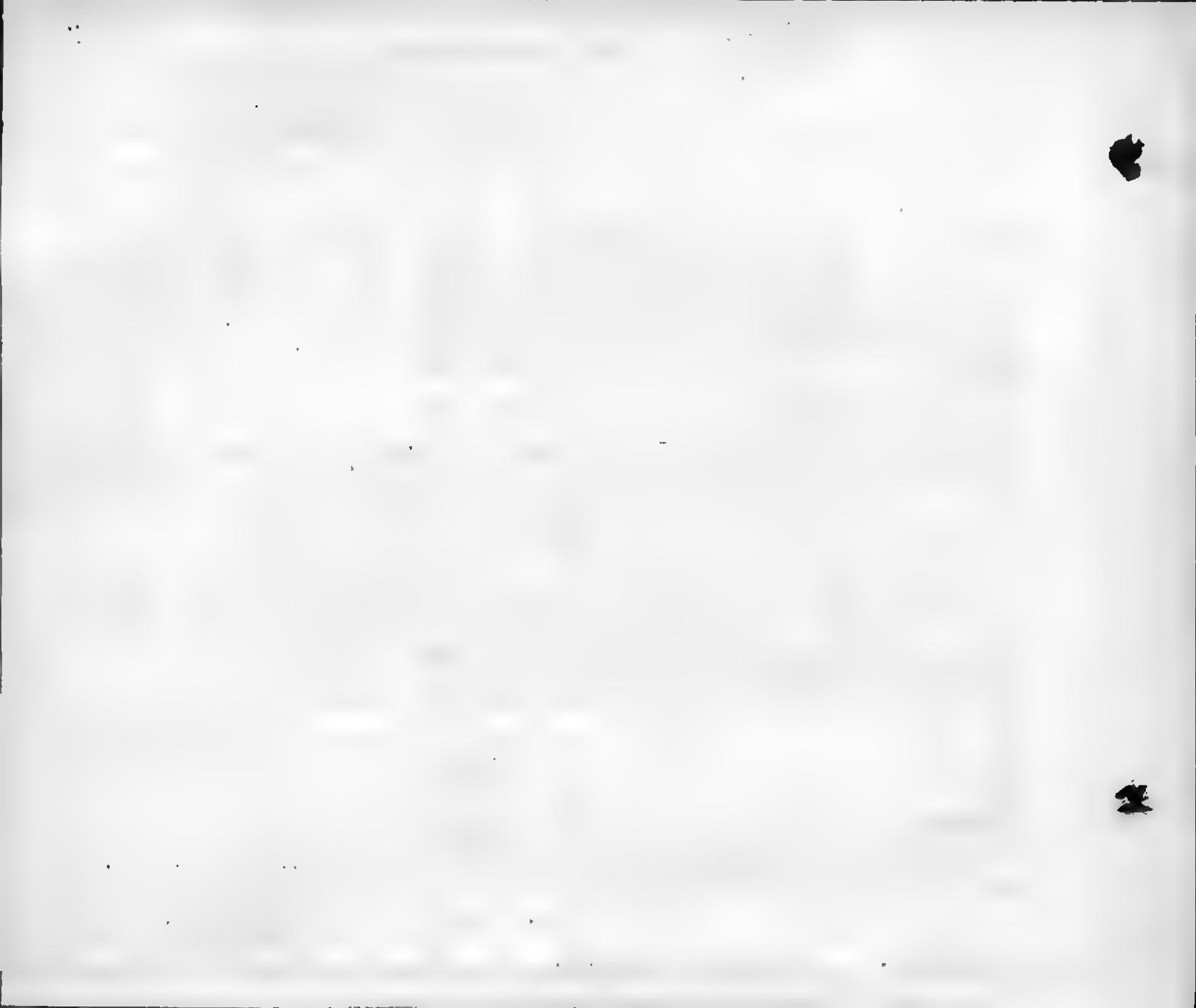
11812

CERTIFICATE OF DEATH

11834

Reg. Dist. No. 308

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Hagerstown		c. LENGTH OF STAY IN lb 40 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		d. STREET ADDRESS 711 Salem Ave	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				d. STREET ADDRESS 711 Salem Ave		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First ROY	Middle EDWARD	Last STOTLER	4. DATE OF DEATH	Month October	Day 31	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb 4 1919	9. AGE (In years last birthday) 39	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. IF UNDER 24 HRS. Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Machine Operator		10b. KIND OF BUSINESS OR INDUSTRY Fairchild Corp		11. BIRTHPLACE (State or foreign country) Hagerstown Wash. Co		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Edward Stotler			14. MOTHER'S MAIDEN NAME Prudence Brumbaugh				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 215-14-1540		17. INFORMANT Mrs. Edwin C. Stotler 711 Salem Ave		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Malnutrition</i> DUE TO 18n x Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) <i>Hypernephroma, l. Kidney</i> DUE TO (c)							
INTERVAL BETWEEN ONSET AND DEATH 6-8 weeks							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>4-14-58</u> to <u>10-31</u> , 1958, that I last saw the deceased alive on <u>10-31</u> , 1958, and that death occurred at <u>430 P.M.</u> from the causes and on the date stated above.							
ADDRESS (Street, city or town, state) Robert F. Keadle, M.D. Hagerstown, Md.							
DATE SIGNED 11-1-58							
ACTUAL SIGNATURE <i>Robert F. Keadle, M.D.</i>		PHYSICIAN'S NAME (Type) Robert F. Keadle, M.D.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial 11/3/58		22b. DATE THEREOF 11/3/58		22c. NAME OF CEMETERY OR CREMATORIUM Cedar Lawn Mem. Gardens		22d. LOCATION (City, town, or county) Hagerstown Wash. Co. Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew V. Coffman Hagerstown Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE NOV 5 '58		24b. REGISTRAR'S SIGNATURE 11-8 Keadle	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18												Reg. Dist. No. 11835	
S. Robert W. Wells, M.D. D.M.E., Wash. Co., 10-7-58 CERTIFICATE OF DEATH													
1. PLACE OF DEATH a. COUNTY Washington MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Washington									
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				c. LENGTH OF STAY IN lb 4 days									
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Washington County Hospital				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown									
3. NAME OF DECEASED (Type or print) WILLIAM HARRISON STOTLER				4. DATE OF DEATH Oct. 6, 1958									
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH August 13, 1888		9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired				10b. KIND OF BUSINESS OR INDUSTRY W.Md.Railroad				11. BIRTHPLACE (State or foreign country) Chewsville, Md.					
13. FATHER'S NAME Wm. Henry Stotler				14. MOTHER'S MAIDEN NAME Ruea Arthur									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? <input type="checkbox"/> (Yes, no or unknown) Yes				16. SOCIAL SECURITY NO. 6/28/18-1/31/19 705-10-5191				17. INFORMANT Mrs. French E. Willis				12. CITIZEN OF WHAT COUNTRY? U.S.A.	
Address 828 Mulberry Ave. Hagerstown, Md.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Bronchitis-Pneu.</i> 491X Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last } (b) <i>Gradual Loss Hip</i> } (c) <i>Arterio-sclerotic Heart D.</i>												INTERVAL BETWEEN ONSET AND DEATH 2 days 10-2-58	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH-BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 20. ACCIDENT WAS UNDERLYING (b) 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) OR CONTRIBUTING (c) CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) Pushed 4 feet on fairground car races												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 4 p. m. <i>Oct 2 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.) <i>Race track</i>		20f. (City or town) <i>Hagerstown Wash. Md.</i>		(County)		(State)			
21. I certify that I attended the deceased from <i>Oct 2 7 1958</i> to <i>Oct. 6, 1958</i> , that I last saw the deceased alive on <i>Oct 6 1958</i> , and that death occurred at <i>4:17</i> M, from the causes and on the date stated above.												ADDRESS (Street, city or town, state) <i>ADDRESS (Street, city or town, state)</i>	
ACTUAL SIGNATURE <i>Sidney Novenstein</i>		M.D. <i>Sidney Novenstein</i>		DATE SIGNED <i>10-6-58</i>									
PHYSICIAN'S NAME (Type) <i>SIDNEY NOVENSTEIN</i>		22d. LOCATION (City, town, or county) <i>Hagerstown Md.</i>											
22e. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22f. DATE THEREOF <i>Oct. 8, 1958</i>		22g. NAME OF CEMETERY OR CREMATORIUM <i>Rest Haven Cemetery</i>		(State)							
23. FUNERAL DIRECTOR'S SIGNATURE Rest Haven Funeral Chapel Inc.		ADDRESS <i>1601 Penna. Ave.</i> <i>Hagerstown, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 9 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Krause</i>							



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11814 CERTIFICATE OF DEATH

Reg. Dist. No. 11836

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		b. COUNTY WASHINGTON	
c. LENGTH OF STAY IN 1b 40 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 218 FREDERICK ST.		d. STREET ADDRESS 218 FREDERICK ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First EDNA	Middle MAY	Last SUMMERS
4. DATE OF DEATH	Month OCTOBER		Day 21
	Year 1958		
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/17/1896
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		9. AGE (In years last birthday) 62	
10b. KIND OF BUSINESS OR INDUSTRY HOME		10. IF UNDER 1 YEAR Months 6 Days 2 Hours 0 Min.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME HARVEY LONG		14. MOTHER'S M AIDEN NAME CARRIE HOFFMAN	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or no or unknown) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT MR. AUSTIN SUMMERS		18. HAGERSTOWN MD.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Cerebral Thrombosis -		INTERVAL BETWEEN ONSET AND DEATH 1 yrs	
Conditions, if any, which gave rise to immediate cause (a), slating the under- lying cause lost. (b) DUE TO General arterio sclerosis -		5-6 yrs.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Hypertension - essential		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Jan 1, 1958</u> to <u>Oct 21, 1958</u> That I last saw the deceased alive on <u>Oct 21, 1958</u> , and that death occurred at <u>10:15 p.m.</u> from the causes and on the date stated above.		ADDRESS (Street, city or town, state) 217 W. Washington St. Hagerstown, Md.	
ACTUAL SIGNATURE Dr. E. W. Ditto III		DATE SIGNED 10/23/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/24/58	
22c. NAME OF CEMETERY OR CREMATORIUM ROSE HILL CEM.		22d. LOCATION (City, town, or county) HAGERSTOWN MD.	
23. FUNERAL DIRECTOR'S SIGNATURE W. J. Horment, Hagerstown, Md.		24a. ADDRESS 24b. REC'D BY REGISTRAR DATE OCT 27 '58	
		24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, file with page 3 should be attached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

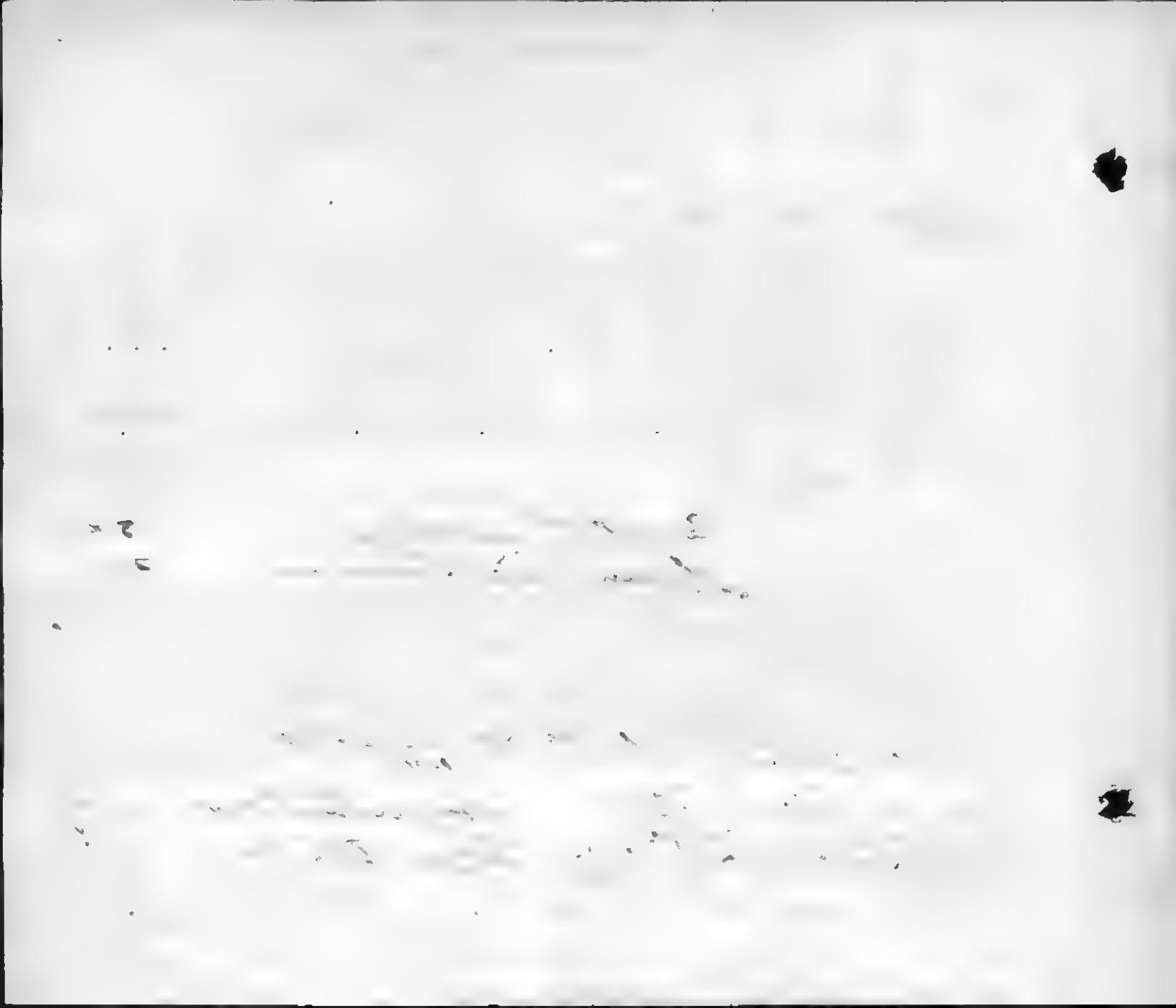
11815

CERTIFICATE OF DEATH

11837

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write in full, Capital and State Name) HAGERSTOWN		b. COUNTY WASHINGTON	
c. LENGTH OF STAY IN lb LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 15 SNYDER AVE.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First WALTER	Middle EDWARD	Last SWEENEY
4. DATE OF DEATH	Month OCTOBER		Day 29
	Year 1958		
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10/5/1899
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FURNITURE FINISHER		10b. KIND OF BUSINESS OR INDUSTRY CABINET CO.	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME EDWARD SWEENEY		14. MOTHER'S MAIDEN NAME ADA KENDLE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO 214-09-2469	
17. INFORMANT MRS. ADMER C. SWEENEY		Address HAGERSTOWN MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (c), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) Gastric Hemorrhage Gastric Ulcer, edema			
INTERVAL BETWEEN ONSET AND DEATH 3 days (3 yrs)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10-26-58</u> to <u>10-29-58</u> , that I last saw the deceased alive on <u>10-29-58</u> , and that death occurred at <u>10-30-58</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) ACTUAL SIGNATURE <u>W. Edward Sweeny</u> M.D. Hagerstown, MD. 10/30/58 PHYSICIAN'S NAME (Type) <u>W. Edward Sweeny</u> Hagerstown, MD. 10/30/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/31/58	
22c. NAME OF CEMETERY OR CREMATORIUM ROSE HILL CEM.		22d. LOCATION (City, town, or county) (State) HAGERSTOWN MD	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. J. Horowitz, Hagerstown, Md.</u>		24a. REC'D BY REGISTRAR NOV 3 1958	
ADDRESS		24b. REGISTRAR'S SIGNATURE <u>W. J. Horowitz, Hagerstown, Md.</u>	



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11847

CERTIFICATE OF DEATH

11838

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGT.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEAR SPRING RURAL		c. LENGTH OF STAY IN 1b LIFE		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CLEAR SPRING RURAL			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CLEAR SPRING HOSPITAL				d. STREET ADDRESS CLEAR SPRING HOSPITAL			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) JOHN		First MIDDLE CALVIN SWORD		4. DATE OF DEATH OCT. 13, 1958		Month Day Year Oct. 13 1958	
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 12, 1872	
9. AGE (In years last birthday) 86 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min		11. IF UNDER 24 HRS			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER				10b. KIND OF BUSINESS OR INDUSTRY GEN. LABOR		11. BIRTHPLACE (State or foreign country) BLAIRS VALLEY	
12. CITIZEN OF WHAT COUNTRY U.S.A.							
13. FATHER'S NAME JACOB SWORD				14. MOTHER'S MAIDEN NAME CATHERINE BLAIR			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT 16 EAST 5th Street, Clear Spring, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)				Carcinoma of Prostate Sclerotic Heart Dis		INTERVAL BETWEEN ONSET AND DEATH 6 yrs 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) BLAIRS VALLEY		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from May 1957 to Oct 10, 1958, that I last saw the deceased alive on Oct 10, 1958, and that death occurred at 6:15 PM, from the causes and on the date stated above ADDRESS (Street, city or town, state) Signature: David R. Brewer M.D. DATE SIGNED 10/13/58							
22a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION		22b. DATE THEREOF OCT. 13, 1958		22c. NAME OF CEMETERY OR CREMATORIAL BLAIRS VALLEY		22d. LOCATION (City, town, or county) BLAIRS VALLEY, MARYLAND	
23. FUNERAL DIRECTOR'S SIGNATURE John F. Clark				ADDRESS CLEAR SPRING, MD.		24a. REC'D BY REGISTRAR OCT 14 '58	
						24b. REGISTRAR'S SIGNATURE Arthur S. Krause	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the register prior to a burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11816

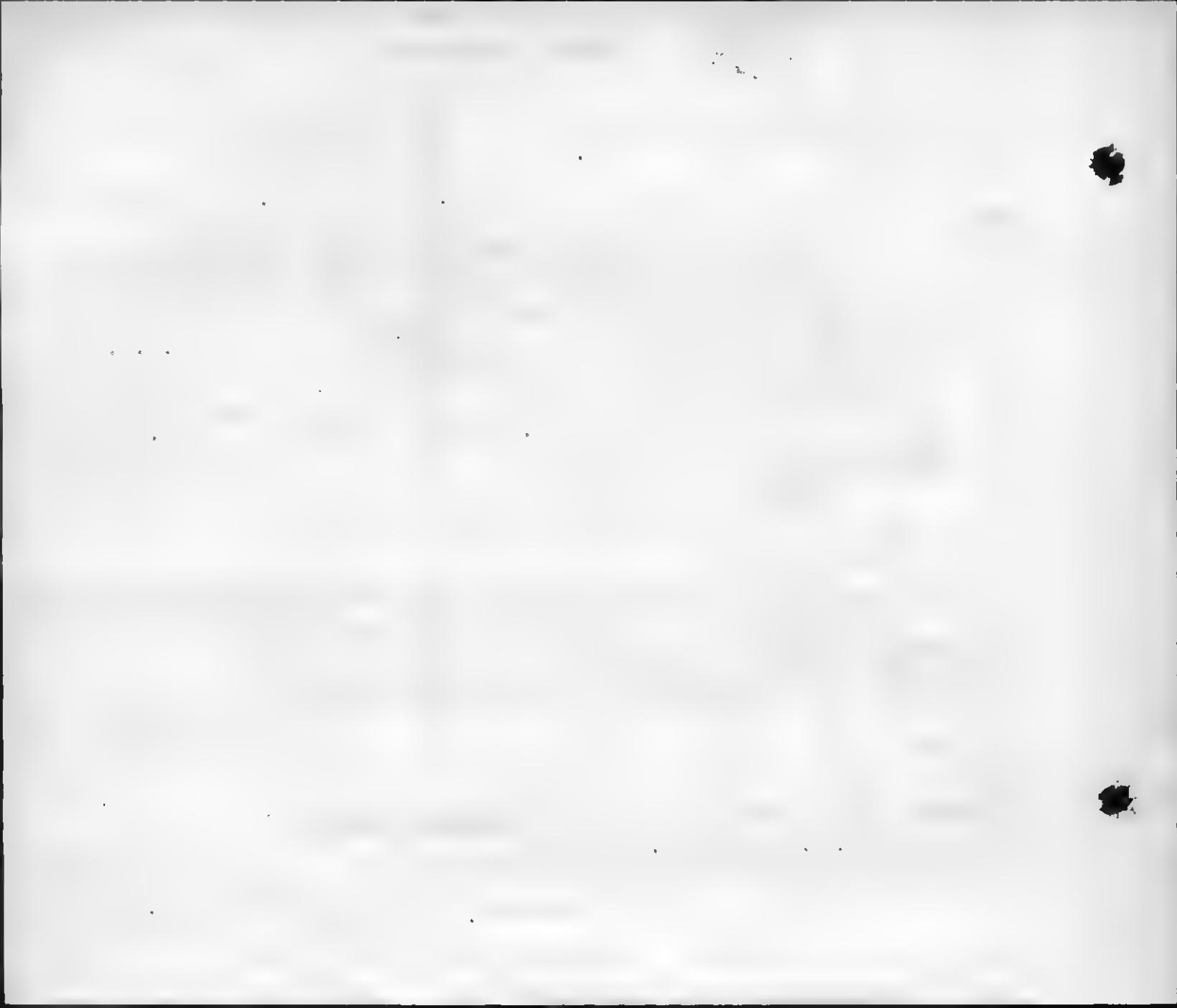
CERTIFICATE OF DEATH

11839

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON		2. USUAL RESIDENCE (Where deceased lived. If institutions Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		b. COUNTY WASHINGTON	
c. LENGTH OF STAY IN 1b 50 YRS.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN	
d. NAME OF HOSPITAL (If not in hospital, give street address) WASHINGTON COUNTY HOSPITAL		d. STREET ADDRESS 312 E. FRANKLIN ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First GRACE	Middle VIRGINIA	Last TRACEY
4. DATE OF DEATH	6/17/1895	Month OCTOBER	Day 20
5. SEX	6. COLOR OR RACE FEMALE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH VIRGINIA
9. AGE (In years lost birthday) 63 yrs.	10. IF UNDER 1 YEAR Months	11. IF UNDER 24 HRS Days	12. IF UNDER 24 HRS Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOMEMAKER	10b. KIND OF BUSINESS OR INDUSTRY HOME	11. BIRTHPLACE (State or foreign country) VIRGINIA	12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME JOHN HENRY	14. MOTHER'S MAIDEN NAME FANNIE ?		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No) No	16. SOCIAL SECURITY NO NONE	17. INFORMANT MR. NELSON CARPENTER	Address HAGERSTOWN MD.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH 2 hours 7 mos.	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour p. m.	Month 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 135 M.D. North Potomac Street, Hagerstown, Maryland
20f. (City or town) Hagerstown	(County) MD	(State) MD	DATE SIGNED 10/20/58
21. I certify that I attended the deceased from 3/28, 1958, to 10/20, 1958, that I last saw the deceased alive on 10/3, 1958, and that death occurred at 315 M.D. from the causes and on the date stated above. ADDRESS (Street, city or town, state) 135 M.D. North Potomac Street, Hagerstown, Maryland			
ACTUAL SIGNATURE <i>J. D. Wilson</i>	DATE SIGNED 10/20/58		
PHYSICIAN'S NAME (Type) J. D. Wilson, M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10/22/58	22c. NAME OF CEMETERY OR CREMATORIUM ROSE HILL CEM.	22d. LOCATION (City, town, or county) HAGERSTOWN MD.
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. T. Horment, Hagerstown, Md.</i>	ADDRESS	24a. REC'D BY REGISTRAR DATE OCT 22 '58	24b. REGISTRAR'S SIGNATURE <i>C. J. S. Evans</i>

HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Lag may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11840

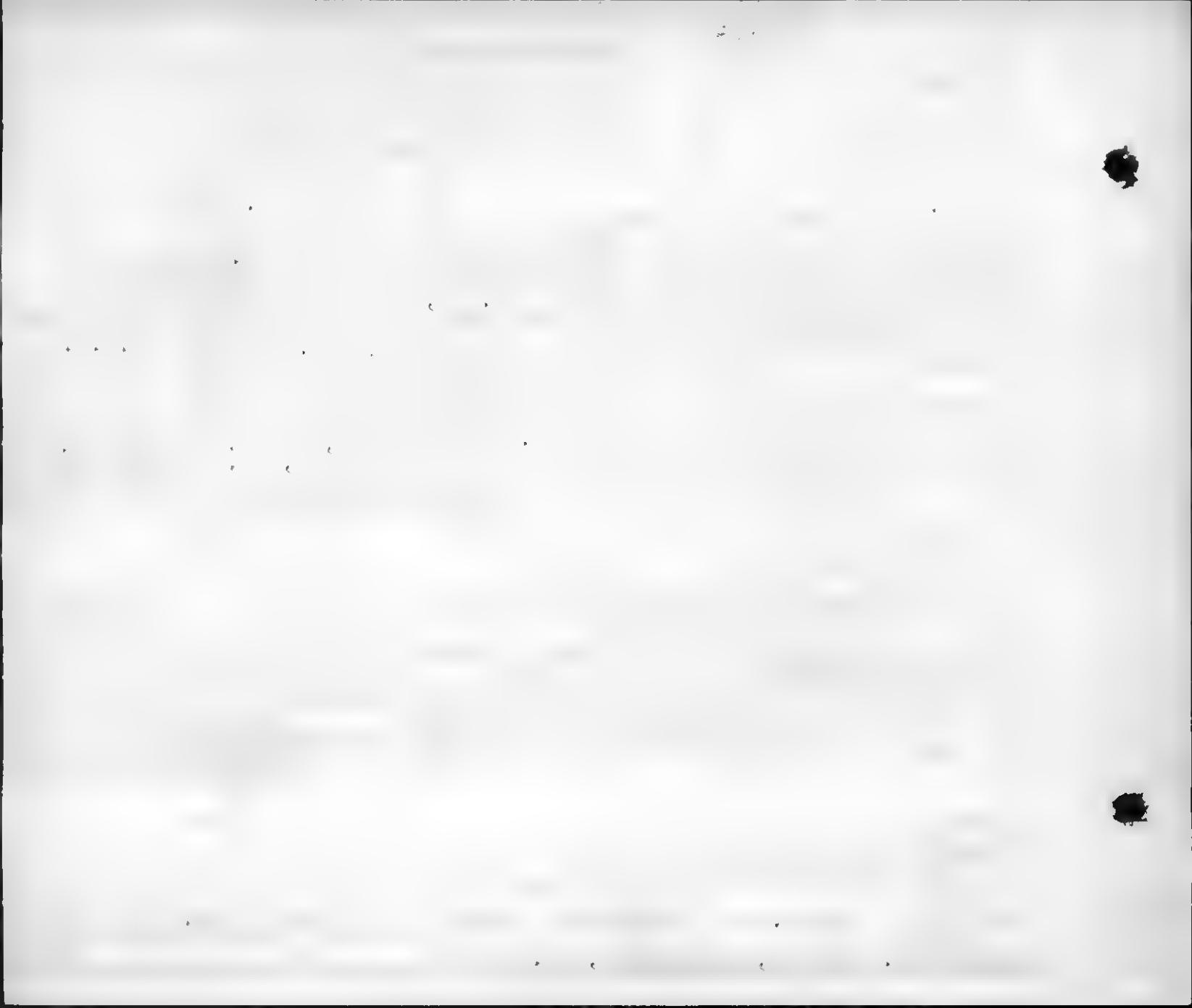
11817

CERTIFICATE OF DEATH

Reg. Dist. No. 303

1. PLACE OF DEATH a. COUNTY Washington		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland		b. COUNTY Washington	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown		c. LENGTH OF STAY IN 1b 5 Hrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Funkstown			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Wash. County Hospital				d. STREET ADDRESS 112 East Green St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First Cora	Middle Lee	Last Takenight	4. DATE OF DEATH Oct. 18	Month 1958	Day	Year
S. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Aug. 17, 1871	9. AGE (In years lost birthday) 87 yrs.	IF UNDER 1 YEAR Months Hours	IF UNDER 24 HRS. Days Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Funkstown, Wash. Cty., Md		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Jacob Kandle				14. MOTHER'S MAIDEN NAME Caroline Gouff			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO none		17. INFORMANT Mrs. Elsie Wesson, 103 S. Potowmick St.		Address Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause lost. (b) Arterio sclerosis DUE TO (c) Hypertensive Cardio-Vascular Disease INTERVAL BETWEEN ONSET AND DEATH 6 hrs 3 yrs							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Oct 18, 1958, to Oct 18, 1958, that I last saw the deceased alive on Oct 18, 1958, and that death occurred at 4 P. M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE Sidney Novenstein M.D. 2000 10-20-58							
PHYSICIAN'S NAME (Type)		SIDNEY NOVENSTEIN					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 10/21/58		22c. NAME OF CEMETERY OR CEMETORY Funkstown Cemetery		22d. LOCATION (City, town, or county) Funkstown, Md. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Andrew K. Coffman, Hagerstown, Md.		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 22 '58		24b. REGISTRAR'S SIGNATURE Coffman 9/14	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be detached for use as the burial-transit permit. Then please remove carbons. Papers 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 24 hours of death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11818

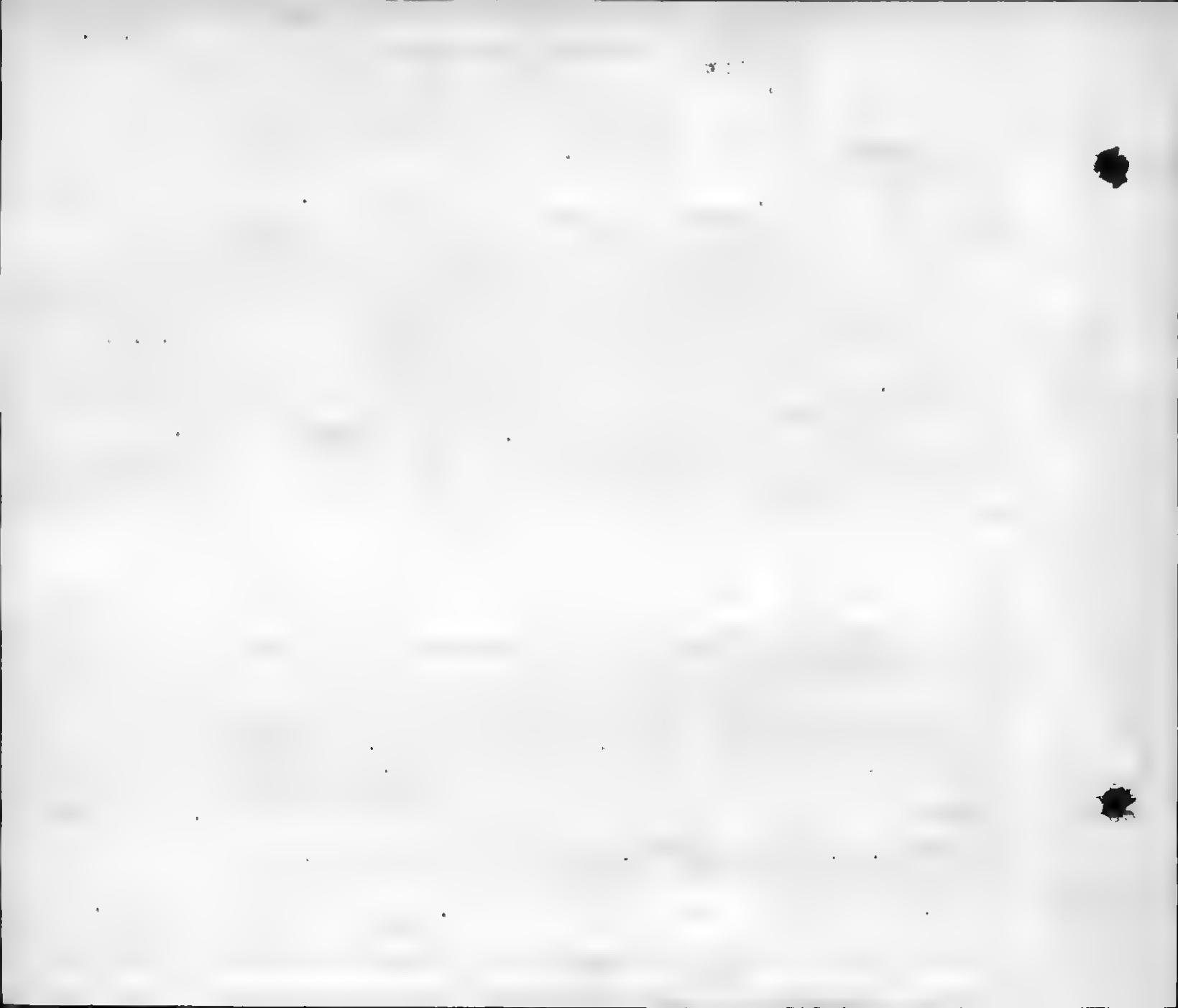
CERTIFICATE OF DEATH

11841

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY WASHINGTON MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE MARYLAND b. COUNTY WASHINGTON	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAGERSTOWN		c. LENGTH OF STAY IN 1b 30 YRS.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 951 CHESTNUT ST.		e. STREET ADDRESS 951 CHESTNUT ST.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) NETTIE		First ARVELLA	Middle WARBLE
4. DATE OF DEATH OCTOBER		Month 24	Year 58 19
5. SEX FEMALE		6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH 4/27/1869		9. AGE (In years last birthday) 89 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY HOME	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JOHN F. GRAY		14. MOTHER'S MAIDEN NAME ANNA ROHRER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or no or unknown) NO		16. SOCIAL SECURITY NO NONE	
17. INFORMANT MRS. PEARL SUMMERS		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) Cerebral arteriosclerosis DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 24 hours	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (\$State)	
21. I certify that I attended the deceased from Oct. 23, 1958 to Oct. 24, 1958, that I last saw the deceased alive on Oct. 23, 1958, and that death occurred at 6:10 A.M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <i>M. Kneisley</i>		M.D. 148 West Washington St., 10/25/58	
PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.		Hagerstown, Md.	

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 10/26/58	22c. NAME OF CEMETERY OR CREMATORIUM SMITHSBURG CEM.	22d. LOCATION (City, town, or county) SMITHSBURG MD.
23. FUNERAL DIRECTOR'S SIGNATURE <i>W. J. Horment Hagerstown, Md.</i>		ADDRESS	24a. REC'D. BY REGISTRAR OCT 28 '58
		DATE OCT 2 8 '58	24b. REGISTRAR'S SIGNATURE <i>Arline S. Horment</i>



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
11819 CERTIFICATE OF DEATH

11842

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Washington		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL and give nearest town Hagerstown		c. LENGTH OF STAY IN 1b 55 years				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 10 N. Mulberry St.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hagerstown				
3. NAME OF DECEASED (Type or print) Lillian		First May	Middle Wasson			
4. DATE OF DEATH Oct.		Month 12	Day Year 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 21, 1896			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife		10b. KIND OF BUSINESS OR INDUSTRY Own Home	11. BIRTHPLACE (State or foreign country) York Pa.			
13. FATHER'S NAME George H. C. Weitzel		14. MOTHER'S MAIDEN NAME Jennie S. Harrison				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) 526X		16. SOCIAL SECURITY NO. 212-24-5996	17. INFORMANT Mrs. Ruth Pryor			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 526X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under- lying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 24m Years Years				
493X 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 493X				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) Hagerstown	(County) Md.	(State)
21. I certify that I attended the deceased from <u>11 Oct</u> , 1958, to <u>12 Oct</u> , 1958, that I last saw the deceased alive on <u>11 Oct</u> , 1958, and that death occurred at <u>8 A.M.</u> from the causes and on the date stated above.						
ACTUAL SIGNATURE <i>Eldon G. Hoachlander</i>		ADDRESS (Street, city or town, state) 115 W. Washington St		DATE SIGNED 10/13/58		
PHYSICIAN'S NAME (Type) Eldon G. Hoachlander		Hagerstown Md.				
22a. BURIAL, CREMATION REMOVAL (Specify) Burial	22b. DATE THEREOF 10-15-58	22c. NAME OF CEMETERY OR CREMATORIUM Rose Hill Cemetery		22d. LOCATION (City, town, or county) Hagerstown Md. (State)		
23. FUNERAL DIRECTOR'S SIGNATURE Minnich Funeral Home		ADDRESS Hagerstown Md.		24a. REC'D BY REGISTRAR DA OCT 16 '58	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF OWNERSHIP

WILMINGTON STATE BANK - WILMINGTON, DE

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for inspection.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/cremation permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE
HEALTH DEPT.

1
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
Item 18 Film 234 10 14 58 2000

11843

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 302

11820

1. PLACE OF DEATH a. COUNTY		Washington MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. LENGTH OF STAY IN lb		d. STATE Maryland b. COUNTY Washington	
Hagerstown		5 months		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ✓	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		/d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Washington County Hospital		814 Mulberry Ave.			
3. NAME OF DECEASED (Type or print)		First	Middle	Last	4. DATE OF DEATH
SUZANNE			CATHERINE	WIBLE	Month October Doy 1 Year 1958
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years from birthday) yrs.
Female		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	May 4, 1958	IF UNDER 1 YEAR Months 4 Days 27 IF UNDER 24 HRS. Hours 1 Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)
none					Hagerstown, Md.
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
Ronald C. Wible			Evelyn Gill		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
no		none		Address Mr. Ronald C. Wible Hagerstown, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pending</i> // - For completion of autopsy report // 492X DUE TO <i>Undetermined at present time</i>					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Virus Pneumonia and hypoplasia adrenal glands					
C (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20e. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
none		none			
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County) (State)
Hour o. m. p. m.	none 19	While of work <input type="checkbox"/> of work <input checked="" type="checkbox"/>	none	-	- - -
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE		S. Robert Wells		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED 10-2-58			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORIAL	22d. LOCATION (City, town, or county)	
Burial		10/4/1958	White Church Cemetery	Huntingdon Co. Pa. (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Suter-Houzer Funeral Home ADDRESS					
24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE DATE OCT 3 '58 <i>Anna S. Trahan</i>					

